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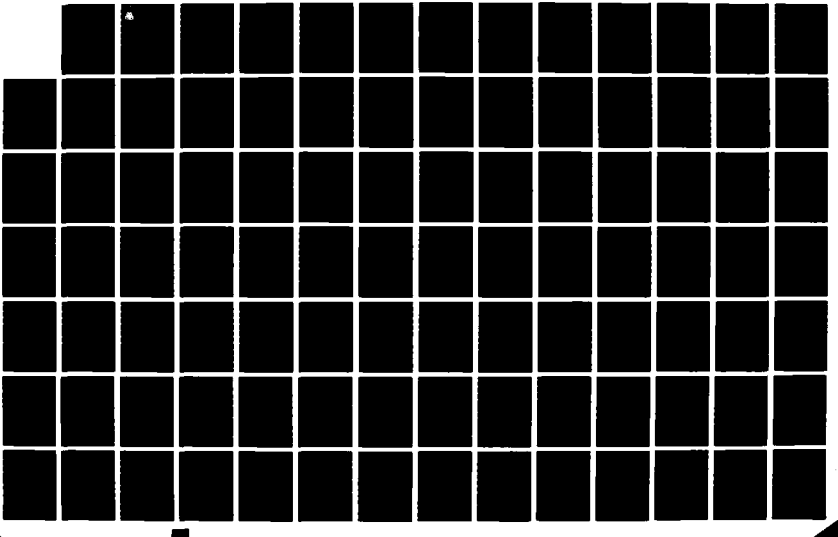

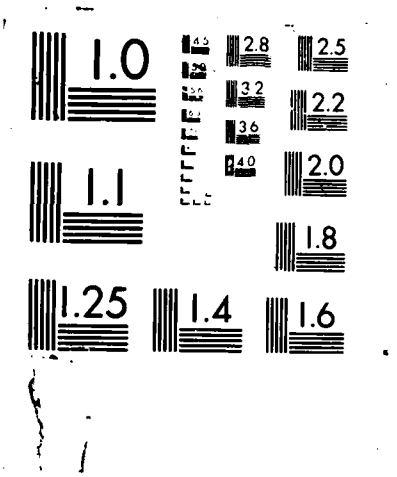
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United States Army Health Care Studies and Clinical Investigation Activity

Health Status of Women in the Army

Final Report

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Report HR87-009

August 1987

US ARMY
HEALTH SERVICES COMMAND
FORT SAM HOUSTON, TEXAS 78234

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Study assigned as part of the FY 84 AMEDD Study Program; examined issue of women soldiers'health care and company level leaders' perceptions of women's health issues. The study was comprised of three separate elements: 1) analysis of Army inpatient data for all active duty Army (ADA) members for 1982-1985; 2) examination of data from the Army's Ambulatory Care Data Base Study to determine morbidity and health care utilization differences between genders for: all active duty Army personnel at six sites over 15 months; for members of 12 randomly selected, cohort male and female basic training (BCT) units at one study site for 12 months; and for ADA members of six randomly selected garrison units for 12 months; 3) interviews with company-level leaders at five Army posts to measure their perceptions of women's health issues. FINDINGS: 1) ADA women utilize health care resources more than do men; 2) in the ambulatory environment, men and women soldiers seek health care for virtually the same reasons,

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predominately musculoskeletal and podiatric in nature; 3) while there is a disproportionate ratio of utilization, it is not perceived as impacting on unit or personal readiness in the peacetime Army by leaders at the company level; 4) when given the opportunity to discuss health care issues, Army leaders chose to focus on "generic" concerns of access to and quality of care rather than gender specific areas. Further, the authors discuss relevant issues surrounding studies of gender differences in health care utilization: preventive care which can inflate numbers of visits, but which in the long run is cost effective for health promotion and early disease detection; and use of the male rates as the sine qua non when gender utilization difference are assessed. The authors suggest that women may not over utilize health care services, but in fact use services appropriately; it may be men who under utilize. The authors offer a caveat to the reader who hears a statement that women in the Army use more health care than men: the ensuing comment could be, "so what?" The point in Army health care is not who uses the least amount of resources, but who uses ~~them~~ most appropriately and what benefit is realized for the Army as a whole. Recommendations included review of ambulatory morbidity and injury rates to possibly modify current training programs and/or develop others, the maintenance of some form of an ambulatory care data base to provide ambulatory epidemiological data for Army and AMEDD leaders, and briefing of study results to US Army Training and Doctrine Command sources.

SUMMARY

The percentage of women in the Army increased from 2% of the active force in the 1970's to 10% of the force in the 1980's. This study examined the issue of women soldiers' health care and company level leaders' perceptions of women's health issues.

Both civilian and military literature identified that women have higher rates of morbidity and health services use than men. Furthermore, the literature is replete with hypotheses assigning causal attribution to these differences. However, explanations of gender differences are issues of interpretation. No single explanatory framework can account for gender differences in illness and medical care.

This study was composed of three separate elements. Analysis of Army inpatient data for all active duty members for 1982 through 1985. Data from the Army's Ambulatory Care Data Base (ACDB) Study were examined for morbidity and health utilization gender differences for all active duty personnel at six sites over a 15 month period of time; for members of 12 randomly selected, cohort male and female basic training (BCT) units at one study site for a 12 month period; and for active duty Army (ADA) members of 6 randomly selected garrison units for a 12 month period. Finally, interviews were conducted with company-level leaders at five Army posts to measure their perceptions of women's health issues.

Review of 416,514 hospital discharge abstracts revealed no substantial changes in male and female hospitalization patterns, rates and averages between the 1982-1985 period and the 1976-1981 period. In general, women had two to three times higher disposition and noneffectiveness rates than did men. Male soldiers showed greater average durations (sick days per case) and lengths of stay for illnesses than did their female counterparts. These results persisted despite controlling for gender-specific diagnoses. However, pregnancy and other reproductive system diseases and disorders continued to account for in excess of one-third of all female disposition and noneffectiveness rates.

From the more than 2.5 million encounters in the ACDB, 848,059 (or nearly one-third) of the entries were attributed to ADA individuals. From the 713,212 diagnoses for both genders, the 50 highest ranked diagnoses accounted for over 55.9% of the total encounters. With the exception of ambulatory visits for normal pregnancies, conditions in the top diagnostic categories were similar for men and women: pain in extremity, normal physical examinations, upper respiratory infections, and sprains/strains. More than 22% of all encounters were for musculoskeletal (M/S) or podiatric reasons.

A total of 1380 visits were reported for the 2454 individuals in the BCT units. Women had more than one-and-a-half times (1.70) the number of reported encounters than men. Although women BCTs sought health care more frequently, the rank ordering of primary diagnoses for men and women were similar with 70.9% of the aggregate encounters for M/S conditions. Pain in extremity and sprains/strains of the ankle were the top two conditions for both genders. Twenty-five percent of all visits were made by 1.7% of the BCT sample. More than three-fourths (76%) of all visits for BCT men and women were for conditions which were resolved in the initial health encounter.

A total of 2934 visits were reported for the 1233 individuals comprising the six garrison units. Women had 1.58 times as many outpatient visits as did men for the same period of time. Twenty conditions explained 50% of the diagnoses for all encounters. The majority of diagnoses were for M/S, respiratory or dermatological reasons. Thirty-six percent of all encounters were for M/S or podiatric reasons. There were two substantial differences in the top 10 diagnoses rankings by gender: nonspecific back pain ranked 2nd for men and 12th for women; depression ranked 8th for men, but 46th for women. Almost 25% of all visits were made by 13 females and 42 males, approximately 4.5% of the sample. Of the total visits, 74.9% were for the first occurrence of a problem.

Finally, 10 interviews were conducted with 23 ADA officers and 61 Noncommissioned Officers (NCOs) (26 women and 58 men). When given the opportunity to discuss military health care issues, leaders chose to verbalize "generic" concerns related to individual or unit readiness/performance and health care quality, rather than gender specific areas. When queried, group participants did not view women's health issues, including pregnancy, as problems which hindered their units' duty performances. In general, health care utilization patterns were not labeled as gender related, but as a function of each individual person.

The study demonstrated that active duty Army women utilize health care resources more than do men. However, in the ambulatory environment, men and women soldiers seek health care for virtually the same reasons, predominately musculoskeletal and podiatric in nature. Finally, while there is a disproportionate ratio of utilization, it is not perceived as impacting on unit or personal readiness in the peacetime Army by leaders at the company level. Recommendations included review of ambulatory data morbidity and injury rates to possibly modify current training programs and/or develop others, the maintenance of some form of an ambulatory care data base to provide ambulatory epidemiological data for Army and AMEDD leaders, and briefing of study results to US Army Training and Doctrine Command sources.

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Due to monumental data collection and analyses tasks, this study has spanned a five year period from its ideation to completion. It is impossible to list all of the individuals and groups providing significant contributions. However, a special acknowledgment is in order for all members of the AMEDD who collected the Ambulatory Care Data Base used for this study.

LTC A. J. Frelin, AN, the original research officer for this study, was reassigned shortly after conceptualizing the original questions and performing the early literature review. Her work provided a solid base for the study. Anne Hoiberg, one of the most productive women's health researchers, graciously met with the principal investigator in San Diego and provided valuable caveats and suggestions.

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Finally, LTC Martha Bell, AN, my co-investigator provided the continual encouragement and attention to detail that makes this report the product it is. Although not originally assigned to the study, she recognized its monumental nature and volunteered to assist. Without her work, completion of the study would not have been possible.

TRM

GLOSSSARY

ACDB - Ambulatory Care Data Base

ADA - Active Duty Army

AIT - Advanced Individual Training

AMEDD - Army Medical Department

AWOL - Absent Without Leave

BCT - Basic Training (or Trainee)

DA - Department of the Army

DOD - Department of Defense

IPDS - Individual Patient Data System

M/S - Musculo-skeletal

MEDDAC - Medical Department Activity

PASBA - Patient Administration Systems & Biostatistics Activity

TMC - Troop Medical Clinic

SAS - Statistical Applications System

SIDPERS - Standard Installation Division Personnel System

STUDY REPORT

HEALTH STATUS OF WOMEN IN THE ARMY

1. INTRODUCTION

a. Background. Planning comprehensive health care and predicting the resources required to deliver health services are not easy tasks. Effectively planning for the health care of beneficiaries requires that managers know the demographics of the population as well as the health needs. Having this information, it is possible to establish priorities for the delivery of services to meet needs, while insuring that correct provider mixes are available. The U.S. Army is no different than any other organization in this respect. Health care planning in the military is more complicated than in the civilian sector because of the Army Medical Department's (AMEDD) dual mission: providing routine health care for solders and their family members during peacetime, and being ready for mobilization.

Heretofore, planning and projecting inpatient services has been possible because information about hospitalized patients has been available through the Army's Individual Patient Data System (IPDS). However, due to the absence of a systematic ambulatory data base, planning for outpatient services has been more speculative.

Because of its impact on readiness and morale, the health status of all active duty personnel is a prime concern to the leadership of the Army as well as the AMEDD. A healthy Army is more likely to realize its full potential in meeting the overall mission of the military. In addition to the mission rationale, health care benefits have always been a significant factor in the recruitment and retention of military personnel. For soldiers to be effective, the military must not only provide care when troops are ill, but must also provide wellness oriented programs, while gaining the soldiers' confidence that their health care is the finest available, anywhere.

As one the largest health maintenance organizations in the world, the U.S. Army has several categories of beneficiaries; however, the active force has priority for all health care services. This is best exemplified by the motto of the AMEDD: "TO CONSERVE THE FIGHTING STRENGTH". Recent changes in health care technology coupled with a change in the demographics of the active Army have potential impacts in shaping the mission of the AMEDD. The gender mix of the Army is one of the most significant changes occurring in troop composition within the past ten years. Whereas women comprised a mere two percent of the force into the 1970s (Department of Defense [DOD], 1984a), based on predictions females currently make up approximately 10% of the active Army (DOD, 1984a). The change in the percentages is mainly the consequence both of the all-volunteer force and recent legislation (Public Law 90-130, 1967) allowing for a higher proportion of women in the Army (DOD, 1984a, p.v). This change is depicted in Appendix 2, Figures D-1 and D-2.

The increased number of women in the Army has met with mixed reactions. Many welcome the integration of women into the active Army; others would seek

to demonstrate that female soldiers, especially in light of their "unique" health care needs, are a liability rather than an asset.

b. Purpose. This study was commissioned as a part of the AMEDD Study Program to examine the issue of women soldiers' health care, both the requirements and ramifications.

c. Objectives. The objectives of this study were:

(1) Compare and contrast health care utilization rates and primary diagnoses for Army active duty soldiers by gender.

(2) Determine whether gender specific health issues are a concern of individuals in leadership positions at the company level.

(3) Identify causal attribution theories to explain differences in health care utilization rates for each gender.

(4) Make recommendations concerning further research and/or intervention strategies which might decrease nonbattle illnesses and injuries for all soldiers, and females specifically.

d. Study Questions.

(1) What are the current inpatient rates and reasons for hospitalization for women versus men soldiers? Has there been a change in the length-of-stay and noneffectiveness rates since The United States Army Patient Administration Systems and Biostatistics Activity (PASBA) published Sex Differentials of Time Lost Due to Hospitalization in 1983?

(2) What are the rates and diagnoses for ambulatory encounters for each gender among active duty soldiers?

(3) Does a difference exist between basic trainees and non-basic trainees in rates of health care encounters and diagnoses made at the time of encounter?

(4) What are the perceptions of company-level leaders regarding women's health issues in relationship to unit effectiveness?

e. Assumptions.

(1) No gender specific coding bias exists in the IPDS.

(2) Only sites which have participated in the Ambulatory Care Data Base (ACDB) study can provide data necessary to examine the outpatient utilization rates.

(3) Basic training units provide the highest level of control for extraneous variables when studying health care differences between men and women.

(4) The health status of basic trainees is equal at time of entry into the Army.

(5) There is no bias in the assignment of men and women basic trainees to a specific company, battalion, or brigade.

(6) All cadre are exposed to both male and female companies during the year due to rotation of assignments.

(7) There is no bias in reporting encounters for men versus women; if reports of encounters are completed for one gender in the troop medical clinic (TMC), they will be completed for the other gender.

(8) Demographic data in the patient registration data base is subject to entry errors, however, there is no reason to believe that errors are systematically biased by gender or race.

(9) Health seeking behaviors are a product of education, socialization, and personal experience.

(10) Because units are gender specific for any given cycle, errors in personnel entries for gender can be safely corrected in a data cleaning routine.

(11) If proper interview techniques are followed, cadre will not be hesitant to reveal their beliefs and feelings about health care services and the issue of women's health.

f. Limitations.

(1) Generalizations can be made only to the population from which the sample is drawn.

(2) Data on health care encounters are retrospective.

(3) Data represent only health care visits and admissions received from Army hospitals, clinics, and aid stations which were a part of the study, and do not reflect illnesses and injuries for which health care was received from other sources to include self-care.

(4) Group interviews of company-level leaders were conducted only at U.S. Army Forces Command (FORSCOM) and U.S. Army Training and Doctrine Command (TRADOC) posts within the southern Continental United States (CONUS).

(5) Because of the interview purposes, group participants could not be randomly selected by the investigators.

2. LITERATURE REVIEW

a. Introduction. Without exception, the literature supports that women use more health care resources than do men. Nathanson (1975) and Verbrugge (1986), two prolific researchers in the area of women's health, best summarize the composite findings. Nathanson (1975) reported, " . . . for all countries where the necessary data are available, women report more acute illness than men, and make substantially greater use of health services. . . " (p. 15). Verbrugge (1986) summarized her comprehensive review of gender-related health utilization issues by stating:

> . . . what distinguishes men and women most is their frequency of illness, injury, health care, and mortality, not the types of morbidity they typically suffer. In brief, what differs most is the rates not the ranks (reasons for seeking health care). This point has been missed heretofore in comparisons of contemporary men's and women's health. (p. 1209)

The literature review was comprised of three major subdivisions: pregnancy issues; gender specific primary health care needs among civilians and active duty soldiers; and both research based and conjectured models or theories addressing health seeking behaviors among men and women.

b. Pregnancy. Although pregnancy issues are not the main thrust of this study, pregnancy is a normal condition for women in the active duty female age group. Therefore, the issue must be addressed whenever female health care is discussed.

In 1967, laws were changed to increase the number of women in the military. Subsequently, decisions were made allowing women to remain on active duty regardless of marital or pregnancy status (Yarbrough, 1985). Much was written regarding the effect of these decisions on the readiness posture of the military services (Binkin, & Back, 1977; Department of the Army [DA] 1982; DOD, 1984b; Dunning, 1978; Hicks, 1978; Hoiberg, 1982; Hoiberg & Thomas, 1982; Webb, 1979; Yarbrough, 1985). Lawrence Korb, Assistant Secretary of Defense for Manpower, Reserve Affairs and Logistics, is credited with stating, " . . . the only sex-specific issue affecting military readiness is that of pregnancy: all other issues associated with combat readiness relate to both men and women" (Purcell, 1982, p. 2). As a consequence of having the young, pregnant soldier on active duty, changes in health care requirements and utilization patterns emerged (Yarbrough, 1985, p. 50). The magnitude of the pregnancy issue is reflected in a statement attributed to an assistant

secretary of defense: "Ten percent of the women in the Army are pregnant at any given time. Over the course of the year, it is estimated that 17 percent of the Army's female personnel will have been pregnant" (Yarbrough, p. 31).

In her longitudinal study to examine rates, diagnoses, and length-of-stay for hospitalized enlisted Navy women between 1966 and 1975, Hoiberg (1980) reported that pregnancy related conditions accounted for nearly one-third of women's hospitalizations; ranking as the number one cause of hospitalization (p. 685). Hoiberg's subsequent study (1982) of inpatient data revealed that between 1974 and 1979, pregnancy related conditions were still the most frequent reason for hospitalization among Navy women, accounting for the second highest number of hospitalized days for women, surpassed only by mental disorders (p. 2). Despite this change in absolute rank-order of diagnoses, noneffective (NE) days (average number of active duty personnel on hospital rolls each day per 1,000 active duty strength; i.e., "lost time") for Navy enlisted women remained greater than that of men, with complications of pregnancy and childbirth accounting for the greatest increase in days lost (Hoiberg, 1979).

Army data essentially mirrored Navy data. In 1983, the U.S. Army Patient Administration Systems & Biostatistics Activity (PASBA) released a report of time lost due to hospitalization for all active duty Army personnel worldwide, for the years 1976 through 1981 (DA, 1983). The female unique diagnoses subgroups of pregnancy complications, childbirth, and the puerperium accounted for the largest incidence of hospitalization for women. Additionally, pregnancy related conditions accounted for 32 to 40 percent of all medically related female noneffectiveness for the years reported (DA, p. 60). Complicated deliveries increased over the six years studied (1979 to 1981), accounting for over 50% of the noneffective rates for the entire subgroup of pregnancy conditions (DA, p. 60).

Ambulatory data for similar periods were unavailable due to the lack of a data base. However, Donlin (1986) reviewed Fiscal Year (FY) 1985 morbidity rates for male and female Navy recruits at a training station in Florida. He reported that the highest outpatient utilization rates for female recruits were for "obstetric [and gynecological] related disorders . . . (which ranged from) complications of previous pregnancies to birth control counseling . . . " (p. 21).

In summary, pregnancy related conditions greatly influence health care utilization rates for females versus males. The data are consistent in placing these conditions as the number one requirement for resources to provide health care for females in the military.

c. Health Care Utilization Patterns

1) Civilian Ambulatory and Hospitalization Data. Verbrugge (1976, 1982, 1986), repeatedly confirmed gender related health care statistics. She analyzed data from several national databases: the 1957 through 1980 National Health Interview Surveys; The 1979 National Ambulatory Medical Care Survey; The 1979 National Hospital Discharge Survey; 1980 morbidity rates from the National Center for Health Statistics; Vital and Health Statistics published by the National Center for Health Statistics; and one community-based series--

The 1978 Health in Detroit Study. Her findings show that patterns of health care utilization, whether from self-reports or from data bases, reveal females with consistently higher age-standardized rates of acute conditions, chronic conditions, and disability due to acute conditions than males. "Women experience more daily symptoms, higher incidence of all types of acute conditions (except injuries at young ages), higher prevalence of nonfatal chronic diseases, more physician visits per year, and more hospital stays. . . removed" (Verbrugge, 1986, p. 1209).

Departing from the traditional reporting, analysis, and discussion of rates alone, Verbrugge (1986) also examined the rankings of daily health problems, chronic conditions, and reasons for office visits and hospitalization for three age specific groups of adults. The first two age groups (young adults [18-44] and middle aged adults [45-64]) are of greatest interest since they include the ages of active duty personnel.

The principal daily health problems were very similar for both young men and women. Respiratory ailments topped the list followed by musculoskeletal (M/S) symptoms, "general" complaints (e.g., tiredness, edema, "ache all over"), nervous system and psychological symptoms (Verbrugge, 1986, p. 1197). The reverse was reported for middle-aged adults' daily health problems. Musculoskeletal symptoms led the list (particularly for women), while respiratory symptoms ranked second for both genders of this age group (Verbrugge, p. 1204).

Chronic diseases or impairments, primarily respiratory disorders due to allergies, existed in only a "small percentage" of young adults (Verbrugge, 1986, p. 1197). In comparison, five chronic conditions stood out for the middle-aged of both genders: arthritis, hypertensive disease, chronic sinusitis, heart conditions, and hearing impairments (Verbrugge, p. 1205).

Office visit statistics reflected the principal daily health problems experienced by young adults. Respiratory visits were the most frequent condition for both sexes, followed by the effects of injuries for men and reproductive disorders, urinary diseases, and weight problems for women (Verbrugge, 1986, p. 1199). Mental distress ranked high for both genders (Verbrugge, p. 1199). Office visits for the middle-aged population centered on chronic diseases; hypertension was the leading reason men and women sought health care (Verbrugge, p. 1206).

Hospitalizations were infrequent for young adults of both sexes in comparison to persons in the older groups. Reasons for hospitalizations did not reflect the most common health problems of the young age group. Injuries were the primary reason for hospital stays for men; reproductive disorders for women; and atypical diseases (e.g., urinary system/gall bladder diseases, alcoholism, hernia, appendicitis, neoplasm) for both sexes (Verbrugge, 1986, p. 1201). Hospital stays for the middle-aged adult closely paralleled reasons for ambulatory care: life threatening diseases, such as malignant neoplasms, cardiovascular diseases, and alcoholism topped the list for males, while women had a "greater diversity of fatal diseases and reproductive disorders" (Verbrugge, p. 1206).

In summary, while the genders differed in the frequency with which they sought health care, there was little difference in the reasons WHY they sought it (Verbrugge, 1986). Verbrugge's analyses are substantiated by others

(Marieskind, 1980; Department of Health and Human Services, 1980a; Nathanson, 1975, 1977). Furthermore, rates and the rank-order of conditions are not unique to the United States population. Nathanson (1977) chose to review data concerning gender differences in mortality, morbidity, and the use of health services in Europe as well as North America. She concluded, " . . . for all countries where the necessary data are available, women report more acute illness than men, and make substantially greater use of health services . . . " (Nathanson, p. 15).

2) Military Hospitalization Data. Morbidity data for the active duty populations closely mirror their civilian counterparts. In this section, military unique literature is reviewed.

a) U.S. Navy Data . When Navy male and female hospitalization rates for 1973 through 1975 were compared, Hoiberg (1980) concluded that hospitalization rates for Navy enlisted women were two to three times those observed for men in virtually all diagnostic categories. This conclusion was supported by Donlin (1986) when reviewing Fiscal Year 1985 data on Navy recruits.

Substantially higher rates for genitourinary disorders were attributed to the "vulnerability of the female reproductive system to dysfunction" (Hoiberg, 1980, p. 689). Higher female rates for digestive disorders were partly explained by "stress-related illness" concepts associating such disorders with "psychosocial stress resulting from significant changes . . . in life situations . . . " (Hoiberg, p. 689) e.g., enlistment. However, other generally frequent problems, foot blisters and cellulitis, were found to be the same for the two sexes. Hoiberg further stated: "Although Navy women had higher total hospitalization rates than men, many of these differences diminished for major diagnostic categories and, in several instances became negligible, when comparisons were conducted within occupational groups" (p. 689). Thus, Hoiberg introduced the variable of "role" as it affects health care utilization. Comparing occupation and pay grades of recruits, Hoiberg identified that the most frequently occurring reasons for hospitalization for the lowest pay grades in all occupations were the same for both sexes: pneumonia, acute upper respiratory infection, medical and surgical aftercare, cellulitis, and rubella (p. 686). There were minimal differences in injury hospitalization rates between Navy men and women within both traditional and nontraditional occupations; although rates for nontraditional personnel were slightly greater when compared to rates for enlistees in traditional jobs (Hoiberg, p. 689). Hoiberg further noted that the differences in rates and ranks which existed between genders in traditional and nontraditional occupations, "narrowed considerably" (p. 689) as the pay grade rose from lower to higher levels.

In two additional reports based on the same data, Hoiberg (1982, 1984) examined the incidence of accidental injuries, noting that female recruits had the highest hospitalization rates between 1973 and 1975 among all Navy women for accidental injuries. She concluded: "(the) results revealed . . . women's relatively high rates for injuries and stress related disorders tended to decrease across pay grade levels thereby suggesting that women's health status improved with time and experience on the job" (Hoiberg, 1982, p. 2). Hoiberg surmised that the differences may not be a function of time and

experience, but due in part to the increased physical and psychological stresses of basic training (p. 2). Holberg and Thomas (1982) further reported that male recruit hospitalization rates for injuries were three times greater than female rates (p. 24).

Finally, Schuckit and Gunderson (1974) studied psychiatric admission rates for Navy men and women, concluding that for those in pay grade E-1 (recruits), the admission rate was four times greater for females than males (p. 534). Donlin (1986) also identified a greater admission rate for female recruits when he reviewed FY 1985 admission data.

b) U.S. Army Data. In the previously cited report from PASBA (DA, 1983), active duty Army (ADA) females were hospitalized more than twice as often as males between 1976 and 1981. Adjusting for gender-specific causes (e.g., pregnancy, childbirth, and the puerperium, and male genitourinary conditions) female hospitalization rates were 44 to 79% greater than for males (DA, p. 60). Female noneffective rates for all nongender-specific diagnoses were greater than male NE rates (DA, p. 60). However, PASBA reported that while hospitalized at higher rates, active duty women had substantially lower lengths of stay than their male counterparts, even when the data were adjusted for gender-specific diagnoses (DA, p. 60). Additionally, the mean number of "sick days" per case, which include any type of inpatient days during one continuous period of hospitalization (e.g., hospital bed days, convalescent leave, supplemental care, travel days between medical treatment facilities, subsisting elsewhere) was greater by 14 to 22% for men than women (DA, p. 3). All reported data demonstrated statistically significant differences at the $p<0.05$ level (DA, p. 60).

PASBA (DA, 1983) further reported statistically significant differences ($p<0.05$ level) between genders' hospitalization and noneffective rates for the category of "all diagnoses" and most of the major diagnostic subgroup categories. Female hospitalization and noneffective rates were higher than male rates. There were two primary exceptions. In the category of circulatory diseases the male rates were greater than those of the females (DA, p. 60); there was no statistically significant difference in hospitalization rates for nonbattle injuries.

A statistically significant difference ($p<0.05$ level) was reported for the nonbattle injury NE rates, with men having a higher rate than females (DA, 1983, p. 60). Motor vehicle accidents (MVAs) were the main causes of injury and reason for males' time lost between 1976 and 1981 (DA, p. 60). MVAs accounted for the main causes of female injury for 1976 and 1981, while poisoning and ingestion/inhalation were the main causes of injury for women between 1977 and 1980 (DA, p. 60).

Active duty Army women had higher hospitalization and noneffective rates for mental disorders, including the improper use of alcohol and drugs, than did Army males (DA, 1983, p. 22). Males had higher average durations and lengths of stay for illnesses in this subgroup (DA, p. 22). PASBA reported these differences as statistically significant at the $p<0.05$ level.

3) Military-wide Data. While identification of ambulatory health care utilization rates [illegible] personnel has been hindered by

the lack of a centralized data base, several efforts have been made to explore gender related health issues. Because of controlled conditions and access to medical reports, many researchers have studied Army and Navy basic trainee populations.

a) U.S. Navy Data. Assessing ambulatory health care utilization at the Naval Recruit Training Command at Orlando, Florida, Donlin (1986) compiled FY 1985 workload and morbidity reports for basic trainees. From the workload data, which included all outpatient visits, he concluded that female recruits sought ambulatory care at a 12% greater rate than male recruits (p. 17). Based upon morbidity data, ranked by category by prevalence, Donlin identified rankings parallel to those cited by Verbrugge (1986) for the same age group. The top four categories were the same regardless of gender: respiratory, musculoskeletal, accidents/injuries, and dermatologic disorders. Donlin stated: " . . . in a broad sense, it might be concluded that there is little notable difference between the groups . . . " (p. 20). However, ranking the categories from greatest to least female-to-male ratio demonstrated: six categories with higher female recruit incidence rates (genitourinary disease; endocrine, musculoskeletal, digestive, circulatory, and dermatologic disorders); four categories with higher male incidence rates (respiratory disorders, infectious and venereal disease, and accidents/injuries); and two categories for which no significant difference in incidence was noted (mental disorders and reactive tuberculin tests) (Donlin, p. 21). With the exception of mental disorders, all ambulatory rankings were similar to those for hospitalization rates of women during training periods. Donlin suggested the lower incidence of mental disorders might be due in part to the 1980 revision of the Diagnostic and Statistical Manual of Mental Disorders, Second Edition (DSM-II). The DSM revision had been acknowledged as a significant change in psychiatric illness classification (Maxman, 1985, p. 35).

b) U.S. Army Data. To date, most Army ambulatory research has focused on basic trainee orthopedic disorders and injuries. The studies support the higher incidence of female-to-male morbidity. In a study using the Health Opinion Survey to predict illness in military trainees, McCarroll, Kowal, and Phair (1981) concluded that females were a higher risk for illness, injury, and failure to complete training than males (p. 466).

A higher female-to-male ratio of lower extremity stress fractures was reported among cadets at the U.S. Military Academy (Protzman, 1976) and among Army basic trainees (Kowal, 1980; Reinker & Ozburne, 1979; Schmidt-Brudvig, Gudger, and Obermeyer, 1982). Additionally, Reinker and Ozburne (1979) identified that women trainees had 5.3 times the incidence of Achilles tendonitis and twice the incidence of chondromalacia patellae (p. 533). Jones (1983) reported that the increasing incidence of lower extremity injuries, affecting over 25% of the males and 60% of the females, has been "exacerbated by the increasing numbers of women being recruited, since during training they experience a much larger, overall incidence of injury than their male counterparts . . . " (p. 783).

Greaves (1983) reviewed ambulatory health care utilization for male and female trainees at an Army basic training center and reported the highest incidence of health problems for both sexes to be musculoskeletal

(representing 46% of both men's and women's complaints for the period). Adjusting for sex specific complaints, the ranking of health problems reflected those discussed by Donlin: respiratory, gastrointestinal, and dermatological complaints.

Cobb (1987) studied the incidence of gynecological (GYN) problems of soldiers to gain insight into the most effective ways to handle such health care needs. She reviewed six months of data on 750 female soldiers seen by a GYN Nurse Practitioner at a garrison TMC and data collected from GYN sick call at a month-long field exercise. Cobb reported that 30% of the TMC visits and 36% of the field visits were for "vaginitis (including sexually transmitted diseases)" (p. 70). Diagnoses requiring further work-up by a physician represented only 9% of TMC visits and 19% of field visits. Routine pelvic exams accounted for a third of the visits to the TMC. She concluded that most GYN conditions were manageable at the TMC or field level provided that necessary supplies and pharmaceuticals were available and the health care provider was familiar with GYN management (p. 71).

In summary, military utilization data reflect reported civilian patterns: male and female utilization rates differ: active duty women utilize inpatient and ambulatory health care more frequently than do their active duty male counterparts. As with women of young ages, when all health requirements are considered, obstetric and gynecological needs are among the highest ranking. Military data also identified that while women seek/require care more frequently than males, when treated, active duty men have a greater duration of illness, and when hospitalized, have a greater average length of stay than women. Thus, Verbrugge's (1976, 1985a) assertions that although women are ill more frequently, they generally experience milder forms of illness, appears applicable to the active duty population. Adjusting for gender-specific complaints, the reasons for which military men and women require health care do not vary: ambulatory care reflects musculoskeletal and respiratory complaints; hospitalization reflects results of injuries (often orthopedic in nature) and respiratory ailments, in addition to mental distress.

d. Gender Health Differences: Why? As the literature is replete with findings documenting that women use/require more health care resources than do men, likewise almost every researcher/writer in this area of study has proposed theories, hypotheses, and conjectures attempting to relate causal attribution to the phenomenon. With varying conclusions, numerous authors have analyzed the gender differences in behavioral responses to health problems (e.g., Brown & Rawlinson, 1977; Chirikos & Nestel, 1982, 1984, 1985; Chirikos & Nickel, 1984; Cleary, Mechanic and Greenley, 1982; Hibbard & Pope, 1983; Marcus & Seeman, 1981; Marcus & Seigel, 1982; Marcus, Seeman and Telesky, 1983; Marshall, Gregorio and Walsh, 1982; Verbrugge & Depner, 1980). The singular question remaining is: Since women use more health care resources than do men, what [illegible] for this increased utilization? In this section the literature [illegible] to enumerate some of the hypotheses and theories which have [illegible] gender differences in both health seeking behaviors [illegible].

From an [illegible] three major domains of influence surrounding [illegible] are here identified: the "iceberg phenomenon" [illegible] in actual health status or predisposition [illegible] factors for

health seeking behaviors. Each domain is examined in relationship to its impact on health care utilization.

Any attempt to measure health status must recognize the "iceberg phenomenon," a concept often cited in epidemiology to contrast the differences between actual incidences of morbidity and the reported incidences. This phenomenon is also cited by Verbrugge (1985a, 1985b, 1986) and Verbrugge and Ascione (1987) to articulate one major problem in examining health care utilization rates by gender. Published statistics focus on severe health problems and publicly visible health actions; in essence, the tip of the iceberg (Verbrugge, 1985a). Verbrugge (1985a) further contends that such statistics do not reveal the frequency and specifics of day-to-day "aches and discomforts" which are ignored or self-treated (e.g., talking with other lay persons, seeking "over the counter" remedies for relief); and which comprise the majority of the illness experiences. While Verbrugge addressed only civilian statistics, her conclusions can undoubtedly be generalized to military populations.

In her comprehensive "state of the issue" paper regarding gender and physical health, Verbrugge (1985a) summarized 15 years of published works in the field and distilled the explanations for sex differences in health into five categories: biological risks of disease; acquired risks of illness and injury; psychosocial aspects of symptoms and care; health reporting behavior; and prior health care:

> Biological and acquired risks determine the occurrence of illness and injury. Psychosocial factors are involved in the social experience of illness that ensues; namely, the perception of symptoms, evaluation of their cause and severity, choice of therapeutic actions, continuation of treatment regimens, and role accommodations made for long-term problems. Further, when people report their health to others, there are added psycho-social inhibitors and inducers to discuss fully their discomforts. Lastly, health care for a current problem can influence one's future health experiences and health attitudes. (p.164)

This is a multivariate concept with a potential synergistic effect produced by the highly interactive nature of the factors. Therefore, the reader is directed to Verbrugge's extensive list of references for individual sources in each of the areas outlined in her paper.

After reviewing the available research, Verbrugge (1985a) concluded that the foremost reasons for gender differences in health were outcomes of the acquired risks from roles, stress, life styles and long-term preventive health practices (p. 173). Psychosocial factors were important, but ranked second to acquired risks: "Women's more active health care of all kinds is due primarily to more experienced and perceived symptoms, and secondarily to the psychosocial factors that encourage care" (Verbrugge, p. 173). Empirical evidence supports her statement (Cleary et al., 1982; Hibbard & Pope, 1983; Verbrugge, 1982). Prior health care, biological risks, and health reporting have lesser effects. Furthermore, she contended that care-provider factors such as physician sex bias, occur with such infrequency that they play a minor role when considering aggregated data for sex differentials (Verbrugge, 1985a., p.173).

Verbrugge (1985a) then proceeded to offer her own theoretical viewpoint: the "relative weights" of acquired risks and psychosocial factors as they influence health seeking behavior varied based upon three characteristics of the health problem: acute versus chronic nature; threat to life; and severity (p. 173). She hypothesized that:

- psychosocial factors have their greatest influence on health seeking behavior for responses to illness or injuries of a chronic, nonfatal, or low severity nature;

- the greatest gender differences in health seeking behaviors are seen in responses to the prolonged, mild conditions. Men and women's perceptions, evaluation and eventually health care utilization will be more similar when confronted with conditions and/or injuries that are acute, fatal or more severe (i.e., conditions over which they had the least amount of control or ability to take self-care actions at their own discretion).

- the more discretion an individual has in seeking health care the greater the influence of the psychosocial factors. The greater the discretion, the greater the gender differences.

Having examined the iceberg phenomenon and differences in health care needs by gender, a final area needing exploration is that of motivation to seek health care. Stages of health is one of the more developed conceptual frameworks to explain health seeking behavior (Fabrega, 1973; Kasl & Cobb, 1966; McKinlay, 1972; Mechanic, 1972, 1978; Suchman, 1965; Stoeckle, Zola and Davidson, 1963). In summary, each stage along a health continuum, and the ultimate health seeking behavior selected by an individual are proposed as reflecting specific decision points:

- whether the individual perceived discomfort or not;

- whether the symptoms were labeled as illness or not and how severe the symptoms were judged to be;

- how the symptoms influenced role performance; and

- whether the symptom could receive self, ambulatory or hospital care (Verbrugge, 1986, p. 1196).

Both severity (degree of bother) and the seriousness (life threat) are key determinates of responses to symptoms. However, demographic and psychosocial factors also impact on illness behavior (Verbrugge, 1986, p. 1196). Differences in the psychosocial factors between men and women result from a broad range of cultural and social forces which shaped their perceptions and attitudes about health. Thus, forces such as childhood socialization (Campbell, 1978; Lewis & Lewis, 1977; Lewis, Lewis and Lorimer, 1977; Mechanic, 1964, 1965, 1980; Philips & Segal, 1969) or adult role commitments (Bishop, 1984; Haw, 1982; Haynes & Feinleib, 1980; Hoiberg, 1980; Nathanson, 1980; Verbrugge, 1983; Verbrugge & Madans, 1985; Waldron, 1980; Woods, 1980; Woods & Hulka, 1979) affect the eventual course of action taken to address a perceived health problem.

In summary, the literature abounds with reports to document that women do use more health care resources than do men. Likewise, the literature is

replete with hypotheses assigning causal attribution to the differences in morbidity, mortality, and health seeking behaviors. Nathanson (1977) concludes that explanations of gender differences are issues of interpretations; there is no single explanatory framework which can account for the numerous processes "grouped together under the general heading of sex differences in illness and medical care . . . selection of a theoretical focus becomes partly a matter of the interests and orientation of the observer . . . " (p. 21). What seems to emerge are causes, events, perceptions, motivations, and choices. How individuals react to an event is contextually tempered by their perceptions of the event and its consequences.

3. METHODOLOGY

The methodology for this study is reported separately for each element: inpatient, ambulatory, and company-level interviews.

a. Inpatient. In 1983, PASBA published a supplement to the recurring inpatient summary reports Health of the Army. Titled Sex Differentials of Time Lost Due to Hospitalization, this review of inpatient data covering the five-year period from 1976-1981 was discussed in the literature review. To ascertain whether there had been any substantive changes in the rates and diagnoses for hospitalized active duty soldiers since 1981, at our request, PASBA analyzed the 1982 through 1985 IPDS, a census of discharge abstracts for all U.S. Army hospitals worldwide for the referenced period. The data included absent sick cases (active duty personnel hospitalized in nonmilitary hospitals). A total of 416,514 abstracts were reviewed: 323,443 (77.7 %) male, 93,071 (22.3 %) female. Rates were calculated using official Department of the Army denominators. Appendix A contains a detailed explanation of terms and formulae used to calculate disposition and noneffectiveness rates, length of stay and illness duration averages, and the percent difference in gender rates.

b. Ambulatory. An analysis of why soldiers present for ambulatory health care and gender specific utilization rates were heretofore unavailable as the Army had no data base of outpatient encounters by diagnosis and procedure. In 1984, the U.S. Army Health Care Studies and Clinical Investigation Activity began a study to capture data on all outpatient encounters at six representative health care facilities within the U.S. Army Health Services Command. To gather data for the current study, a post with a large basic training center was purposefully included among the six sites. The purposes of the Ambulatory Care Data Base Study (ACDB) were to provide epidemiological data, describe services provided, and document workload statistics. Because the current study was already in the planning stages at the time of the ACDB inception, it was possible to include data elements of interest for this study.

Outpatient data in the ACDB were captured at the battalion aid station or troop medical clinic, and at all specialty clinics. For the first time, an Army data base allowed the comprehensive tracking of health care episodes in an automated fashion.

ACDB data were captured on mark-sense forms using preprinted menus of standard ICD-9-CM diagnostic codes (U.S. Department of Health and Human Services, 1980) and CPT-1985 procedure codes (Clauser, Fanta, Finkel, Perlman, 1985). The ICD-9-CM codes were inpatient oriented and CPT codes designed for physician performed services and procedures. AMEDD ambulatory health care is delivered, and must be accounted for, by other allied providers, such as physical and occupational therapists, optometrists, social workers, physician's assistants, nurse practitioners and community health nurses, in addition to physicians. Therefore, the investigators, in conjunction with ambulatory care providers, augmented the published codes with additional items to enable the capture of detailed data needed in the AMEDD outpatient system. This also served to provide face validity for the data capture instruments.

In several instances, the diagnostic label reported from the ACDB was not an exact match to those found in the standard code books. When the ICD-9-CM codes were initially augmented, common language diagnoses from the Army's ambulatory algorithms were substituted for the more "scientific" diagnosis, primarily because these diagnoses were ones used by first eschelon providers during the triage processes. For example, "runny, stuffy nose" was substituted for "chronic rhinitis" because that was what appeared in the enlisted medics' algorithm handbook.

Appendix C includes a copy of the ACDB Primary Care Form, the most commonly used instrument to record outpatient visits for the ADA soldiers. In addition to forms such as the one for primary care, a "short form" was used to record brief visits for procedures such as immunizations, review of shot records, and blood pressure checks (see Appendix C for a complete list of the short form procedures). It is important to note that capture of diagnostic information was *not* the purpose of the short form. Therefore, encounters captured via the short forms were included in the total visit counts, but obviously, were not included in diagnoses analysis.

As one of the most frequently occurring diagnoses or reasons for visit, "No problem noted," requires explanation. This diagnosis was specifically chosen by providers in almost 9% of the combined ADA data. "No problem noted" was used most frequently to indicate follow-up of a resolved condition, or as a diagnosis for a visit during which no abnormal findings were found. Most importantly, it did not indicate the absence of a diagnosis.

For the current study, reliability checks of 498 records were carried out at five ACDB study sites to determine if data entered on encounter forms and subsequently in the data base, were the same as the information in the outpatient record for the same encounter. Percent of match for primary diagnoses was 89.7%, deemed acceptable by the investigators.

For the current study, ambulatory data were examined at three levels: 1) all active duty troop encounters in the data base; 2) data from garrison units; and 3) data from basic training cycles. All analyses included aggregate and gender-specific data. Rates were calculated using official Standard Installation Division Personnel System (SIDPERS) denominators for units.

First, data were examined to calculate the frequency of primary diagnoses for all outpatient encounters by ADA personnel at all six ACDB sites for a

fifteen-month period of time. The data are presented as an analytical base line prior to exploration of the basic training and garrison level data.

From nearly 2.5 million outpatient encounters in the ACDB, 848,059 or nearly 33.4% of the entries were attributed to active duty Army individuals. Approximately 135,000 (16%) of these encounters were captured on ACDB short forms. When all primary diagnoses or reasons for visit (n=713,212) were examined, the list included several hundred discrete diagnoses. To most efficiently manage the data, in most cases only the 50 highest ranked diagnoses are reported for each set of analyses.

To represent non-basic trainee posts, a large Army installation was used to draw a sample of units for analysis, using a step-down sampling procedure. From the entire ACDB, a list of units at the post was generated including the number of active duty individuals registered by gender. Medical Department Activity (MEDDAC) and Combat Support Hospital personnel were not included to prevent bias since this was an AMEDD study. Furthermore, it was believed that "medics" often receive undocumented health care from colleagues. This would create under-reporting for such units. All remaining units composed of at least 10% women were selected for further sampling. From a list of all units meeting inclusion criteria, using a table of random numbers, six companies were selected for further analysis. To calculate denominators for rates, each unit's average monthly strengths were obtained from the post. The period of time chosen for analysis was one calendar year (1 April 1986 through 31 March 1987). Data were exported from the ACDB to a SAS file for more detailed analysis.

Of the garrison sample (N= 1233), males comprised 85.2% (n=1050) and women comprised 14.8% (n=183). For the garrison troops, the mean age of individuals who received ambulatory health care was 27.14 years (S.D.= 7.66); for females 24.63 years (S.D.=4.836); and for males 27.678 years (S.D.=8.043).

To create the basic training (BCT) sample, unit strength reports were obtained detailing all BCT units at the selected post for the period of 1 April 1986 through 31 March 1987. All 50 companies in 10 battalions from two brigades were aggregated into a SAS file for analysis.

All female training cycles were numbered in a serial manner. A table of random numbers was used to select six units, three female cycles from each of the two brigades. Next, a male company within the same battalion, and having a cycle start date within three days of each female unit, was selected to serve as a matching company. This procedure produced six cohorts. For practical purposes, the only difference in units was gender. To protect unit identity, groups were numbered one through twelve with female units comprising the odd numbered groups and male units comprising even numbered groups.

Season-of-the-year was not used as a stratifying criterion. Instead, season was allowed to enter the randomization process. Denominator data for each training cycle was obtained from post-level data and used to calculate the mean cycle strength. Patient demographics were obtained from the patient registration data base portion of the ACDB, which was a product of the post-level personnel tapes (SIDPERS).

The sample of 2454 individuals consisted of 1171 (47.7%) women and 1283 (52.3%) men. The mean age of the BCTs receiving health care was 21.1 years

and ranged from 17-35 for females (M=21.4; S.D.=4.24) and from 17-36 for males (M=20.2; S.D.=3.33).

A verification check of rank was made for a sample of the basic trainees. This procedure was to insure that only the ranks of E-1 through E-3 were in the data set, and that cadre were in fact not grouped into the units. Finding no problems, no further rank edits were done. A check of patient gender revealed that less than one-half of one percent of the data were incorrectly coded for gender. Since units were gender-specific, a data cleaning procedure was accomplished to correct gender coding.

c. Interviews. The final study component proposed to measure the perceptions held by company-level leaders regarding women's health issues. In essence, did leaders at this level perceive a gender difference in health problems and use of health care?

At the study outset, interviews were conceptualized as a means to develop a survey instrument regarding women's health issues. The instrument was to be given to a probability sample of active duty Army members. However, during the interview phase little variance was found in participant responses. Hence, a decision was made to use the interviews rather than questionnaires to answer this study question.

Because this was an AMEDD study, the study director originally requested that only non-medical unit personnel be included in the interviews. The plan was to measure line-oriented perceptions. However, since the interview of medical personnel did not incur additional costs, it was decided to interview select members of AMEDD units to determine whether line and medical units' perceptions about women's health issues would vary.

The Adjutant General's (AG) office at four posts were contacted to coordinate the interviews. Contact points at the medical post were the Brigade Commanders. The points of contact were informed of the purpose of the interviews, but were asked not to divulge the information, thereby possibly biasing interviews. Specific instructions were given concerning the sample desired.

At two posts, division units with women assigned were used to draw a sample of personnel to be interviewed. Within each division, two groups of company commanders and first sergeants were identified to participate in the group interview sessions. Job descriptions of participants at the remaining three posts varied, although all held leadership roles at a company level. At the BCT post, interviewees were officer and non-commissioned officer (NCO) cadre assigned to basic training companies. At the medical post, participants were composed of NCO cadre responsible for training students assigned to the medical advanced individual training course (91A10).

A total of 10 interviews were conducted with 84 participants. Of the 23 officers and 61 enlisted personnel participating in the group sessions, 26 (30.9%) were female and 58 (69.1%) were male. Except at one post, all participants held positions such as Drill Instructor, Company Commander, or First Sergeant. Officers held the rank of First Lieutenant or Captain. Enlisted personnel were Staff Sergeant or higher in rank. In the one exception to the cited sample composition, at one post junior enlisted

personnel were included to provide an opportunity for varying opinions.

One-hour interview sessions with combined groups of men and women soldiers were conducted at four Army posts. At a fifth post, men and women were purposely interviewed separately to eliminate possible gender interactions among participants. At this post, the female interviewer met alone with a group of female officers and NCOs; and the male interviewer met alone with enlisted men. The interview schedule and approach to the questions was the same regardless of the group composition or site.

Interviews were performed by a female field grade AMEDD officer and a doctorally prepared male field grade social worker with expertise in group process. To keep participant's reticence at a minimum, the setting (in a prearranged garrison area) and tone of the sessions were as informal as possible. Participants were assured any notes taken by the interviewers would be general in nature relating to the issues raised, and that no comments would be attributed to any named individual. Participants were told that data collected would be used to develop topics for possible management studies to be conducted by the Health Care Studies Division of the Health Care Studies and Clinical Investigation Activity.

Individuals were assured that their comments would be reported neither individually nor by unit, but as an aggregate thereby maintaining anonymity. Because the interviewers outranked all of the interviewees, there was concern that those being interviewed might not be frank. Using general health care issues and concerns as a "barometer", it was apparent that the interviewed individuals had no hesitancy in discussing the topics.

For purposes of standardization, an interview schedule was utilized to systematically cover three areas of investigation: general health care, troop health, and female health care. However, group sessions were purposefully unstructured enough to allow for spontaneous comments from the interviewees. A "funneling" technique, described by Straus, Gelles and Steinmetz (1980) was used. This technique allowed information about sensitive topics to be obtained by moving from the general to the specific (i.e., general health care issues to women's health), while gaining the confidence of those being interviewed. Notes were made during the interviews by each of the researchers, compared and collated immediately after each of the sessions.

To initiate discussion, each participant was asked to list on a piece of paper four problems, issues, or topics relating to troop health care that should be discussed. While health care for active duty personnel was stressed, participants were told any health care issues could be discussed including family member care, because such issues could have an effect on troop performance. If, after other general discussion, issues relating to women were not raised by participants, the interviewers introduced the topic.

In summary, in addition to an extensive review of the literature, three methods were used to answer the study questions. These included: examination of inpatient data, analysis of the ACDB, and interviews with company-level officer and enlisted leaders.

4. RESULTS

The results section is presented in three parts: inpatient; ambulatory; and company-level interviews.

a. Inpatient Data. Appendix A contains the 1982 through 1985 data summary compiled by PASBA regarding gender specific inpatient statistics for ADA personnel.

1) Pregnancy. Pregnancy related conditions accounted for slightly more than one-third of all female dispositions (34 to 37%, Table A-14b), and over one-third of all female noneffectiveness (37 to 43%, Table A-14c) for 1982 through 1985. However, health related NE rates decreased from 41% in 1982 to 37% in 1985 (Table A-14c). Disposition and NE rates increased for the diagnoses comprising "Complications of Pregnancy" (24 to 31% and 18 to 26%, respectively) (Tables A-14i; A-14j), but decreased (22 to 17% disposition rate and 27 to 21% NE rate) for uncomplicated deliveries. (Tables A-14i; A-14j)

2) Non-Gender Specific Diagnoses. Controlling for gender-specific diagnoses, the female hospitalization rate was 31 to 43% greater than for men (Table A-2); noneffectiveness rates for women were 8 to 26% greater than for their male counterparts (Table A-2). However, men had longer average durations of illness (13 to 26%) and lengths of stay than women soldiers (Table A-2).

Review of Appendix A tables revealed statistically significant differences ($p<0.05$) between gender disposition rates and noneffectiveness rates for each diagnostic-specific subgroup. In all but three categories, circulatory system diseases (Table A-10a), alcoholism (Table A-8d), and nonbattle injuries (Table A-19a), that difference was reflected in higher rate for females. However, there were inconsistencies among years and between genders for average duration and average lengths of stay. That is to say, for some years within a diagnostic category, there was no statistically significant difference between average duration for genders or for average lengths of stay for genders. Yet for other years within the same category, there were statistically significant differences. Because of these inconsistencies, the reader is directed to tables containing data of specific interest.

Motor Vehicle Accidents were the most frequent cause of trauma admissions for men during all years, and in 1984 for female trauma admissions. The most frequent cause of trauma admissions for women between 1982 and 1983 were "complications of other medical procedures", and for "poisoning, ingestions/ inhalation" in 1985.

b. Ambulatory.

1) Overview of Ambulatory Analysis. Ambulatory analyses were executed at three levels: the aggregate ACDB data for active duty Army;

garrison units; and basic training units. The aggregate data were analyzed to provide a listing of the most frequently occurring diagnoses in the entire data base. The garrison and BCT data were analyzed by gender to determine the differences in rates of encounters, rank order and frequency of diagnoses, the percentage of eligible individuals actually using the health care facilities, and the number of different episodes of care in contrast to the number of encounters.

2) Aggregate ADA Personnel. Tables B-1 through B-3 provide an overview of the top 50 primary diagnoses for all active duty soldiers of both genders combined, and for female and male soldiers separately by gender for the 15 month period of time. From the 713,212 diagnoses for both genders, the 50 highest ranked diagnoses accounted for over 55.9% of the total encounters (Table B-1). When the data were examined by gender, the top 50 ranked diagnoses accounted for 59.9% and 57.9% of the diagnoses for women and men, respectively (Tables B-2 and B-3). Six diagnoses accounted for almost 25% of all female visits. For men seven diagnoses accounted for 25% of all visits.

Almost six percent of all female soldier visits were for normal pregnancies. Otherwise, conditions in the top diagnostic categories were similar for both genders: pain in extremity, normal physical examinations, upper respiratory infections (URI), and sprains/strains (Tables B-2 and B-3). In fact, 22.46% of all encounters were for musculoskeletal or podiatric reasons.

Table B-4 provides an alternate view of the data by summarizing the previous three tables. Using all active duty diagnoses as the base, the top 50 diagnoses are rank-ordered for comparison of the aggregate and each gender. No tests of statistical significance were performed. These rankings are provided to assist the reader to make comparisons for conditions of interest.

3) BCT Data. Representing all BCT units at one post for a twelve month period of time, the six randomly chosen female BCT cycles along with their matching male cycles were carefully examined. The sample consisted of 2454 trainees (1171 females and 1283 males). Table B-5 displays the week-by-week census of the twelve units, including attrition rates and average strength figures used for denominator data in the remaining calculations. Of the six matched groups, in only one case did the attrition rate for men exceed that of their paired female unit.

Table B-6 lists the visit rate per individual per cycle for each of the twelve groups. Rates ranged from a low of 0.22 for one group to a high of 0.98 for another group. From a total of 1380 health care encounters, the average number of visits per person during an eight week training cycle was 0.56; 0.716 (n=839) for women and 0.422 (n=541) for men. Therefore, the rate of ambulatory encounters for women was 1.70 times greater than that for men.

Table B-7 presents the primary diagnoses for the 12 BCT groups combined. M/S and podiatric reasons were the most frequent, comprising 70.9% (n=979) of all trainee diagnoses. Pain in extremity and sprains/strains accounted for 27.5% (n=380) of all visits. Thirteen diagnoses comprised 49.7% of the total visits.

Table B-8 shows the frequency of diagnoses (n=839) for the female BCTs. Thirteen diagnoses accounted for 49.8% of all encounters, with the majority of the visits made for M/S complaints. Pain in extremity and sprains/strains accounted for over 27% of all diagnoses, while 70.6% (n=592) of all diagnoses for female BCTs were for M/S or podiatric reasons.

Table B-9 provides a frequency list of the diagnoses for all 541 male encounters. Three diagnoses (all M/S), pain in the extremity, sprain/strain, and stress fracture, accounted for in excess of one-third of all visits, while 11 diagnoses which accounted for almost one-half of the male visits. With the exception of URIs (n=13; 2.4%) and psuedofolliculitis barbae (n=12; 2.2%), the top 52% of all male visits were for M/S or podiatric reasons. For all male BCT diagnoses, 71.5% (n=387) were for M/S or podiatric reasons.

Table B-10 provides a list of the diagnoses rank ordered by frequency of occurrence for the combined BCT units and by gender. Tests of statistical significance were not performed. Examination of the rank ordering revealed that pain in extremity and sprains/strains of the ankle were the top two conditions for both genders. Within the top ten diagnoses, two stand out as different for the genders. Back pain ranked higher for women (fifth versus twelfth for men); while stress fracture of the pubic rami ranked higher for men (sixth versus nineteenth for women).

Of the total 1380 visits, 25% (n=340) were reported for 42 individuals. Fifty percent of the visits (n=690) were made by 128 or 5.2% of the individuals. Stated another way, 25% of the BCT ambulatory encounters were made by 1.7% of the sample.

Of the 839 female encounters, 25% of all visits (n=211) were made by 26 or 2.2% of the possible 1171 women. One female had a total of 13 encounters. Nine individuals accounted for almost 11% of all female visits. Twenty-five percent (n=135) of the 541 male encounters were made by 17 (1.3%) out of a possible 1283 men. Five men made almost 11% (n=59) of the visits.

Some conditions were resolved in one health care encounter, while others required several return visits. By counting only the first time a diagnosis was recorded for any one individual, an attempt was made to examine "episodes of care." Collapsing data in this manner, the 1380 encounters decreased to 1018 episodes. Therefore, 74% of the visits for the combined BCT groups were for new problems/reasons and 26% were for repeat or follow-up visits for a previously diagnosed condition. When examined by gender, a single episode or care accounted for 76.0% (n=636) for women and 70.6% (n=382) for men.

4) Garrison Level Analysis. After analyzing the list of total active duty diagnoses and those for basic trainees, garrison level analysis was undertaken on six randomly selected non-medical units. For a one-year period 1233 soldiers (183 females and 1050 males) had 2934 reported encounters; 635 (21.6%) for women and 2299 (78.4%) for men. This equated to an overall rate of 2.38 outpatient encounters per soldier for the year; 3.47 per woman and 2.19 per man. Therefore, in the garrison sample, women had 1.58 times as many outpatient visits as did men for the same period of time.

Examining all diagnoses for the combined garrison units (Table B-11), six conditions accounted for 26.2% of the encounters. For the garrison sample, 21 conditions explained 50% of the diagnoses. The majority of the top diagnoses

for garrison units were musculoskeletal, respiratory, or dermatological in nature with 36% (n=1057) of all garrison level diagnoses for M/S or podiatric reasons. However, 2% (n=58) of all diagnoses were for depression, the tenth highest ranked diagnosis for active duty members at this installation.

Table B-12 provides the diagnostic data for the 632 female encounters. The leading diagnoses were pain in extremity, gastroenteritis, and URI. M/S and podiatric diagnoses accounted for 34.3% (n=217) of all garrison female diagnoses.

Table B-13 covers the 2299 male diagnoses. Back pain, URI, and pain in extremity were the leading conditions. M/S and podiatric diagnoses accounted for 36.5% (n=840) diagnoses.

Table B-14 provides a comparison of the rank ordered diagnoses for the entire garrison sample and for each gender in the garrison. Within the top ten diagnoses for each gender, two stood out as substantively different for the two genders. Nonspecific back pain, the second most common diagnosis for males was the twelfth ranked diagnosis for females. Depression, the eighth ranked condition for men, was the forty-sixth ranked diagnosis for women. Whereas depression accounted for 2.4% of all visits for males in the garrison sample, it only accounted for 0.5% of the female visits.

The highest number of encounters reported for any one individual was 18 for one woman and 56 for one man. Examining these data from another perspective, 13 females and 42 males made almost 25% of the visits for their respective cohort.

Looking at the episodes of care data, 2199 (74.9%) of all visits were for the first occurrence of a problem for a given individual; 79.1% (n=502) for women and 73.8% (n=1697) for men.

c. Interviews. In each of the ten groups, participants initially addressed issues that affected unit and individual readiness/performance. Among the most frequently mentioned were problems regarding the amount of time spent obtaining health care and the resulting time lost to the units. Contributing to the issue of lost time and frustration with the military medical care system in general were: the loss of portions of medical or dental records, particularly laboratory and radiology reports which precipitated repetition of the test and further follow-up visits; and the lack of properly trained personnel or necessary equipment at the TMC to treat diagnosed conditions, which required additional appointments at a "hospital" specialty clinic.

Other examples cited by interviewees as perceived reasons for delays in health care included the numerous levels of screening a patient must endure before seeing a physician; the various places an individual must "carry a slip of paper" and wait in a line for portions of the required care (e.g., lab, x-ray, records room), the distances one may have to travel between the TMC and hospital or specialty clinic, and the "shortage of doctors." Further issues identified as impacting on readiness included: the use of quarters for "inappropriate" lengths of time or conditions; profiles which conflicted with regulations or which were perceived as unrealistic; barriers to health care such as restricted clinic appointment hours for active duty personnel; the

lack of timely communication from the hospitals to the units when troops were hospitalized; and the lack of adequate medical support during field training exercises.

In addition to unit/individual performance issues, group participants verbalized concern with issues they perceived as "quality of care": the lack of courtesy or apparent concern for troop welfare on the part of health care providers and support personnel; lack of continuity of care (inability to see the same provider for similar problems); perceptions that retirees and family members who had more "interesting" problems received priority for treatment. Some of the participants indicated a preference for civilian medical care because they perceived it to be of a higher quality than military health care.

In none of the interviews, including groups comprised solely of women, were issues identified regarding women and women's health care utilization or needs until prompted by the interviewers. Interviewees perceived no differences in the quality of care that females received in contrast to that received by males, nor in gender related use of medical facilities. Participants generally indicated that time lost because of excessive use of quarters, sick call, medical appointments, etc., depended on the individual involved and that each case was different. Any problems arising from excessive duty loss were attributed to the individual, not necessarily to that person's gender. No generalizations were made about whether women or men lost more time or had more profiles which reduced their ability to function.

Although many of the participants related individual anecdotes about the problems "other" units had with women, most summarized that, in their own experiences, when women soldiers were "sick", female responses were generally the same as men. If a difference existed, women were thought to be more likely to seek health care "sooner," relieving the problem earlier, and thereby more promptly returning to duty more promptly.

The following example from an interviewer's diary, while verbalized by one NCO, was reiterated in different forms throughout most groups when female health issues were finally introduced:

> The NCO, whose unit had a "large percentage" of female troops, stated his observation was that females were given more quarters, not for "female" problems, but for colds, etc., and that females and junior male soldiers went on sick call more frequently than senior male soldiers. He suggested perhaps the first group was "smarter" in wanting to catch problems early and be "cured" while the older males had a "macho" need to "tough out" illnesses. He said this might explain why the women and younger men were given 24 hours quarters and the older ones 72 hours quarters, i.e., because the older men were sicker. He stated the total hours lost to quarters by the two groups in his unit seemed to balance.

When the issue of pregnancy was discussed, group members agreed that the length of time lost from work depended on the individual. Frequently, group members chose to present examples of the number of pregnancies their troops had experienced. It was cited that while some women worked up to the end of a

performance. However, pregnancy profiles were not perceived to be any different from other profiles and the ensuing duty limitations.

In summary, when given the opportunity to discuss any military health care related issues, company-level officer and NCO leaders chose to verbalize "generic" issues related to individual or unit readiness/performance and health care quality, rather than gender specific concerns. In every group interview, the topic of women's health care needs and/or utilization issues had to be introduced by the interviewers during the final portion of the hourly session.

5. DISCUSSION

The two questions included in this study's charter were answered. The questions dealt with rates of health care utilization by active duty Army women as compared to men, and the perceptions of women's health issues by Army leaders at the company level.

As in the civilian sector, active duty Army females used more inpatient and ambulatory health care resources than did men. Inpatient services for women are primarily linked to conditions related to the reproductive processes of pregnancy, childbirth, and the puerperium. Such conditions accounted for more than one-third of all hospitalizations and noneffectiveness ratings for women in both the Army and the Navy.

Ambulatory care utilization rates were derived using two Army samples, one among basic trainees and the other among garrison units. The respective rates for female encounters were 70% and 59% higher than those for men. The direction of the findings was not surprising. As Lois Verbrugge (1985a), one of the most productive researchers in the area of gender related health issues stated:

> As long as vital statistics, health surveys, and medical/hospital records have been available for the United States population, they have shown higher mortality rates for men, but higher rates of morbidity and health services use for women. (p. 156-157)

It would appear that no matter where or how rates of health care utilization are examined, women use more health care resources than do men. This study has confirmed these findings for the Army samples studied. Of note is the fact that even with all of the controls in the basic training groups, encounter rates were 70% higher for women.

It must be borne in mind, however, that in the basic training environment, there are only two health classifications for the soldier: "fit for duty" or "hospitalization." Any condition which might impede optimum performance of duty would be grounds to seek health care regardless of gender. Hence, if some of the theories concerning differences in health seeking behaviors (Verbrugge, 1985a; "stages of health," Suchman, 1965) were

operational, one would have expected to see less of a spread in rates among men and women in basic training. One speculates, therefore, that other factors were in operation. "Acquired risks," such as biological factors, most likely outweighed psychosocial factors influencing health seeking behaviors.

Several authors (Kowal, 1980, Jones, 1983) have offered biological and physiological reasons for the greater incidence of musculoskeletal injuries in women BCTs: elasticity in connective tissues, higher percent of body fat, less lean body mass (muscle), wider pelvis, and femoral anteversion. These anatomical factors, coupled with a lower level of physical conditioning before assuming arduous physical fitness programs may account for the increased incidence of injuries.

The percentage of all ambulatory health care encounters for active duty members of either gender for M/S reasons is noteworthy. Prior military studies (Hoiberg, 1984; Jones, 1984; Kowal, 1980; Reinker & Ozburne, 1979; Schmidt-Brudvig, et al., 1982) have offered several suggestions regarding changes in physical training and equipment to decrease training injuries. Either the suggestions have not been implemented or they have not been effective as the numbers of M/S conditions in the current study were extremely high. It could be argued that since the basic trainees were in good health, young, and essentially free of chronic medical conditions, the only types of diagnoses remaining would be from injuries. However, it was the sheer numbers of M/S and podiatric encounters, not merely their rankings or rates, which were remarkable. If physical fitness programs were properly conducted, with appropriate precautions taken by trainers and trainees alike, why were the numbers so high?

Although it is not known how she operationally defined M/S conditions, Greaves (1983) reported that 46% of all encounters among BCTs at the same post as the current study were for M/S reasons. The current study found almost 72% of all ambulatory encounters among BCTs were for M/S or podiatric problems. Even in the garrison, or "seasoned" troops, 36% of all outpatient visits were for M/S or podiatric reasons. The questions for the Army and the AMEDD become: What are acceptable injury levels, what can be prevented, and how can prevention be facilitated?

Two other notable points regarding utilization rates must be addressed: individual rates of encounters and "episodes of care." For both the BCT and garrison units, a very small percentage of men and women accounted for an inordinately large number of health care visits. Additionally, within both samples, more than 70% of all visits for both genders were for new problems/reasons. Evidently, the majority of problems for both men and women soldiers were acute in nature and required only minimal attention, i.e., one visit. Conditions other than "return to duty" (e.g., "quarters", prescribed "follow up" therapy, etc.) would have been documented as a repeat encounter for the same diagnosis. Therefore, although a large number of encounters occurred, the severity of the conditions were minimal in the vast majority of instances.

The mandate for the present study was to examine utilization rates by gender. This was done. The investigators would be remiss, however, not to emphasize some relevant methodological and philosophical issues surrounding studies of gender differences in health care utilization. Not only is health a difficult construct to measure, but the question of what constitutes

"appropriate" or "acceptable" levels of health care resources is value laden and relative within the context of the inquirer's perspective.

When examining health care utilization rates, some individuals view utilization as a negative attribute. For example, female utilization rates are usually compared to those of men, as if male rates were the ideal. A problem with the foregoing philosophy, whether covert or overt, is that it causes standards to be established as deviations from the male rates, thereby placing the male utilization rates as the sine qua non. The idea of "less is better" cannot be accepted unquestioned, especially in the area of health prevention. Possibly, as the literature demonstrates, men under utilize health care resources for primary and secondary prevention, as well as delaying treatment for acute problems. Stated another way, women may not over utilize health care services. They may, in fact, use services appropriately. Perhaps men under utilize.

One cannot label the absolute number of health care visits or encounters as inately good or bad. From a preventive medicine perspective, health promotion and early disease detection may be cost effective in the long run, although the number of health care encounters by any individual are increased in the short term. For example, effective physical therapy following many injuries often entails a high number of encounters. However, the therapy may be resource effective by making the long term outcome positive for the patient and the "health care insurer." Likewise, routine pelvic examinations for women have been deemed effective in the early detection and treatment of carcinoma. Finally, increased numbers of prenatal visits have been linked to positive outcomes in pregnancy. All of these preventive and early detection programs result in increased numbers of encounters. Encounter rates cannot be the only measure of effectiveness in health care.

Finding that gender rates for utilization of health care were similar to those in the civilian and Navy sector, the second question addressed by the current study examined company-level leaders' perceptions concerning women's health. Women's health issues were not seen as a serious problem by those interviewed. They did not label health care utilization patterns as gender related, but as a function of each individual person. It would seem that changes in attitudes have taken place over the past few years concerning the place of women in the military.

The AMEDD should note that the company leaders interviewed did question whether the AMEDD was as efficient as it could be in handling the health care problems of the active force. This issue deserves attention. It makes no difference that a soldier's health care is of the highest quality if the recipient does not perceive it as such. It would appear that the AMEDD has a public relations problem, if not an actual problem. The interviews were conducted prior to the inception and introduction of the U.S. Army Surgeon General's current public relations campaign, entitled "We Care", designed to address such issues. Follow-up assessment will be required to determine if perceptions have changed.

As a condition affecting women the age of those on active duty, pregnancy always surfaces as an issue whenever women's health is discussed. Therefore, a few comments are in order. Women's health issues, and specifically pregnancy, were not deemed substantive by the company-level leaders, although pregnancy related conditions accounted for the largest percentage of all

hospitalizations and noneffectiveness for Army women, and pregnancy related conditions and diagnoses surrounding the female reproductive organs accounted for 12% of all ambulatory encounters for women soldiers.

The company-level leaders seem to have grasped the essence of the pregnancy issue: It seems irrational to make a decision to bring women of childbearing age into the Army, allow them to marry and to have families, and then to make the normal condition of pregnancy a health care utilization issue. That is taking a normal life process and equating it to a negative event, merely because it requires resources. Although pregnancy is not an issue in the peacetime Army at the company level, that does not mean that it could not become a readiness or political issue. Likewise, it may be more of an issue at higher command levels than at the unit level, since no survey was done at higher command levels. Perhaps, if 10% of all women in the Army continue to be pregnant at any one time, consideration should be given to raising Army personnel levels accordingly to compensate for the related impact on readiness.

Finally, great care must be taken in using the data presented in this report. The reader should be cautious when hearing a statement that women in the Army use more health care than men. The ensuing comment could be, "So what?" It may be that more important questions in Army health care are not <u>who uses the least amount</u> of health resources, but <u>who uses them most appropriately</u> and what benefit is realized for the Army as a whole.

6. RECOMMENDATIONS

a. The results of this study should be disseminated widely, especially the perceptions of the interviewees. Perhaps by communicating the findings, prejudices and invalid thinking might be corrected.

b. A briefing of the findings should be offered to TRADOC to encourage dialogue and examination of the methods used in physical training (PT) programs. As a minimum, experts in physical medicine, physical education, sports medicine, and physical therapy should examine the conditions presenting for health care to determine if the rates are acceptable. The high incidence of musculoskeletal conditions would indicate that evaluation research is needed to test various experimental models for achieving physical conditioning without high levels of injury. In a peacetime setting it may not be necessary to achieve full physical conditioning in an eight week period. Perhaps PT started in BCT could be continued during AIT with the first Army Physical Fitness Test for record occurring at the completion of AIT, or at some other milestone such as six months in the Army.

c. Continue a data capture system such as the ACDB to enable the monitoring of diagnoses, thereby allowing assignment of the correct provider mix and the assessment of training needs for conditions most frequently seen. Furthermore, if any changes in training are made, an encounter tracking system will be necessary to monitor changes occurring as a result of the experimental intervention.

d. Since health care is one of the major recruitment and retention benefits realized by soldiers, continued assessment of concerns such as those arising during the study interviews is needed. If problems actually exist in the delivery of health care to the major beneficiary, they need to be examined and corrected if possible. If there are no problems, but merely misperceptions, these also need to be corrected.

e. The findings of this study have implications for the health promotion programs currently being proposed throughout the Army. As Machiavelli (1950) wrote in The Discourses more than four centuries ago, "Wise men say, and not without reasons, that whoever wishes to foresee the future must consult the past; for human events ever resemble those of preceding times . . . " (p. 530).

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APPENDIX A

Gender Differentials for Time Lost to Hospitalization

Male and Female Active Duty Army Personnel

Worldwide, 1982-1985*

* Data tables prepared by the US Army Patient Administration System and Biostatistics Activity (PASBA), Fort Sam Houston, Texas 78234, December, 1986.

AN AID TO DATA INTERPRETATION

Various measurements were used by personnel at PASBA to calculate different gender requirements for medical care and time lost due to hospitalization. The following definitions and formulae are provided to assist with data interpretation.

HOSPITALIZATION/DISPOSITION RATE: The terms can be used interchangeably for purposes of this report. According to PASBA procedures, cases were added to the data base upon disposition from the hospital. A disposition as used to describe Army data, occurred when an ADA inpatient concluded a specific period of treatment and was released from an Army's medical treatment facility's (MTF) control. Dispositions included discharges to duty, absent without leave (AWOL), deaths, disability and administrative separations, and retirements which were terminations of MTF inpatient care. Since "return to duty" was the most frequent method of disposition, some analysis reflected in the following tables was restricted to "duty only" dispositions, although "total dispositions" received equal attention. Rates were expressed as the number of dispositions per 1,000 average ADA strength per year.

Formulae:

For females: $\frac{\text{Dispositions of female inpatients during the CY}}{\text{Average female ADA strength for the CY}} \times 1{,}000$

For males: $\frac{\text{Dispositions of male inpatients during the CY}}{\text{Average male ADA strength for the CY}} \times 1{,}000$

BED DAYS: Days a patient was assigned to a hospital bed.

AVERAGE LENGTH OF STAY (ALOS): Average number of bed days per case; further subdivided into "duty only dispositions" and "all dispositions."

Formulae:

For females: $\frac{\text{The number of bed days for female inpatients during the CY}}{\text{The number of dispositions for female inpatients during the CY}}$

For males: $\frac{\text{The number of bed days for male inpatients during the CY}}{\text{The number of dispositions for male inpatients during the CY}}$

SICK DAYS: Days spent on hospital rolls from the initial day of admission until the day of final disposition. Sick days include all bed days, convalescent leave, supplemental care, absent sick bed days, subsisting elsewhere, travel days between MTF, and any other type of inpatient days possible during one continuous period of hospitalization.

AVERAGE DURATION: Sick days per case; analyzed for "duty only dispositions" and "all dispositions." For certain diagnostic groups and types of cases average duration can be substantially greater than average length of stay since the former accounts for an entire period of illness (which may be spent in and out of a hospital proper) and the latter only for the time physically present in a hospital.

Formulae:

For females: $\frac{\text{The number of sick days for female inpatients during the CY}}{\text{The number of dispositions for female inpatients during CY}}$

For males: $\frac{\text{The number of sick days for male inpatients during the CY}}{\text{The number of dispositions for male inpatients during CY}}$

NONEFFECTIVE RATE (NER): Average number of ADA personnel on daily hospital rolls per 1,000 ADA strength. All patients in a "sick day" status comprised the number of "noneffective" personnel during a specified period.

Formulae:

For females: $\frac{\text{Sick days for female inpatients during the CY}}{\text{Average female ADA strength x days in the CY}} \times 1{,}000$

For males: $\frac{\text{Sick days for male inpatients during the CY}}{\text{Average male ADA strength x days in CY}} \times 1{,}000$

PERCENT DIFFERENCE: The difference between genders for the above measures is reflected by percent. The sign preceding the percent number indicates the direction of the difference. A positive percent difference indicates a higher (although not necessarily a statistically significant difference between genders) female value while a negative percent difference shows a greater male rate. Data values presented in the tables were rounded to one decimal place; however, all percent differences were calculated using full, nonrounded values.

Formulae: $\frac{\text{Female-Male}}{\text{Male}} \times 100$

STATISTICAL TESTS: Testing was performed at the 0.05 level for male versus female for each reported year. Disposition rates and noneffective rates were tested using a chi-square 2X2 contingency table. Testing was not done for NE rates which were equal when rounded or where less than 0.1. A Student's t was used to test for statistically significant differences between male and females in average duration and average length of stay. Statistically significant differences between genders were indicated with an asterisk (*). No statistically significant difference was indicated by an "NS" notation.

DATA SOURCE LIMITATIONS: Data were extracted from the Individual Patient Data System (IPDS) and include ADA patients hospitalized in US Army medical treatment facilities and absent sick cases (ADA personnel hospitalized in nonmilitary hospitals). ADA patients admitted to other Uniformed Services hospitals, carded for record only (CRO) cases, personnel treated on an outpatient basis, and "quarters" cases were not included in the data.

Each record contained in the IPDS was based upon the Inpatient Treatment Record Cover Sheet (ITRCS) prepared at the time of patient disposition. The diagnostic codes recorded in the ITRCS were based upon the International Classification of Diseases, 9th Revision (ICD-9) for data from 1982 through 1985. All cases were classified by diagnosis using the only reported condition, or, for patients with more than one diagnosis, the specified "primary diagnosis."

Table A-1

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: All Diagnoses

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	83,892	81,742	79,392	78,417
Female	22,865	22,907	23,207	24,092
Disposition rate per 1000				
Male	118.8	117.4	113.7	112.7
Female	309.0	301.4	305.4	312.9
% Difference	160	157	168	178
Probability	*	*	*	*
Average duration, all cases				
Male	16.2	16.7	17.3	17.6
Female	14.0	14.6	14.3	14.7
% Difference	-14	-13	-18	-16
Probability	*	*	*	*
Average duration, duty cases				
Male	12.6	12.0	11.9	11.7
Female	12.5	12.8	12.3	11.9
% Difference	-1	7	4	1
Probability	NS	*	*	NS
Average length of stay, all cases				
Male	9.2	8.8	8.7	8.2
Female	5.9	5.8	5.6	5.4
% Difference	-35	-35	-35	-33
Probability	*	*	*	*
Average length of stay, duty cases				
Male	7.6	7.2	7.1	6.9
Female	5.1	5.0	5.0	4.8
% Difference	-32	-31	-30	-30
Probability	*	*	*	*
Noneffective rate				
Male	5.3	5.4	5.4	5.4
Female	11.9	12.0	11.9	12.6
% Difference	125	124	121	132
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$

Table A-2

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: All Diagnoses Excluding Gender Specific Diagnoses

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	81,217	79,307	76,670	75,673
Female	12,056	11,337	11,567	11,947
Disposition rate per 1000				
Male	115.0	113.9	109.8	108.7
Female	162.9	149.2	152.2	155.2
% Difference	42	31	39	43
Probability	*	*	*	*
Average duration, all cases				
Male	16.5	17.0	17.7	18.0
Female	13.1	14.0	14.5	15.9
% Difference	-21	-18	-18	-11
Probability	*	*	*	*
Average duration, duty cases				
Male	12.8	12.1	12.0	11.9
Female	10.1	10.4	10.5	10.2
% Difference	-21	-14	-13	-14
Probability	*	*	*	*
Average length of stay, all cases				
Male	9.3	9.0	8.9	8.4
Female	7.6	7.5	7.4	7.1
% Difference	-18	-16	-17	-15
Probability	*	*	*	*
Average length of stay, duty cases				
Male	7.7	7.3	7.3	7.0
Female	6.1	6.0	6.1	5.8
% Difference	-20	-17	-16	-17
Probability	*	*	*	*
Noneffective rate				
Male	5.2	5.3	5.3	5.4
Female	5.9	5.7	6.0	6.8
% Difference	12	7	14	26
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$

Table A-3a

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Disease

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	66,899	66,103	63,899	62,086
Female	21,364	21,493	21,792	22,472
Disposition rate per 1000				
Male	94.8	95.0	91.5	89.2
Female	2,887	282.8	286.7	291.8
% Difference	205	198	213	227
Probability	*	*	*	*
Average duration, all cases				
Male	15.4	15.7	16.8	17.5
Female	14.0	14.5	14.2	14.7
% Difference	-9	-7	-15	-16
Probability	*	*	*	*
Average duration, duty cases				
Male	11.8	11.3	11.3	11.4
Female	12.6	12.9	12.4	12.0
% Difference	6	14	9	6
Probability	*	*	*	*
Average length of stay, all cases				
Male	8.8	8.4	8.5	8.1
Female	5.8	5.6	5.5	5.3
% Difference	-34	-34	-35	-34
Probability	NS	*	*	*
Average length of stay, duty cases				
Male	7.2	6.9	7.0	6.8
Female	5.0	4.9	4.9	4.7
% Difference	-31	-30	-30	-31
Probability	NS	*	*	*
Noneffective rate				
Male	4.0	4.1	4.2	4.3
Female	11.1	11.2	11.1	11.7
% Difference	178	175	165	175
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$

Table A-3b

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Disease Excluding Gender Unique Diagnoses

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	64,224	63,668	61,177	59,342
Female	10,555	9,923	10,152	10,327
Disposition rate per 1000				
Male	91.0	91.5	87.6	85.3
Female	142.6	130.6	133.6	134.1
% Difference	57	43	52	57
Probability	*	*	*	*
Average duration, all cases				
Male	15.7	16.0	17.2	18.0
Female	13.0	13.8	14.4	16.0
% Difference	-17	-14	-16	-11
Probability	*	*	*	*
Average duration, duty cases				
Male	12.0	11.4	11.5	11.6
Female	10.0	10.2	10.4	10.2
% Difference	-17	-11	-10	-12
Probability	*	*	*	*
Average length of stay, all cases				
Male	9.0	8.6	8.7	8.3
Female	7.6	7.5	7.4	7.1
% Difference	-16	-13	-15	-15
Probability	*	*	*	*
Average length of stay, duty cases				
Male	7.4	7.1	7.2	7.0
Female	6.1	6.0	6.1	5.9
% Difference	-18	-16	-15	-16
Probability	*	*	*	*
Noneffective rate				
Male	3.9	4.0	4.1	4.2
Female	5.1	4.9	5.3	5.9
% Difference	30	23	28	40
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$

Table A-4

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Infectious and Parasitic Diseases

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	5,150	5,514	5,263	5,245
Female	1,002	900	1,036	1,119
Disposition rate per 1000				
Male	7.3	7.9	7.5	7.5
Female	13.5	11.8	13.6	14.5
% Difference	86	49	81	93
Probability	*	*	*	*
Average duration. all cases				
Male	8.7	7.9	7.6	7.6
Female	6.8	8.3	6.2	6.8
% Difference	-22	4	-18	-11
Probability	*	NS	*	NS
Average duration, duty cases				
Male	7.8	6.9	6.5	6.3
Female	6.5	6.4	5.6	5.5
% Difference	-16	-7	-13	-14
Probability	*	NS	*	*
Average length of stay, all cases				
Male	5.8	5.2	4.9	4.7
Female	4.6	5.2	4.3	4.0
% Difference	-21	0.0	-12	-15
Probability	*	NC	*	*
Average length of stay, duty cases				
Male	5.5	4.9	4.7	4.4
Female	4.5	4.5	4.2	3.8
% Difference	-19	-10	-10	-14
Probability	*	*	*	*
Noneffective rate				
Male	0.2	0.2	0.2	0.2
Female	0.3	0.3	0.2	0.3
% Difference	44	56	48	72
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$
NC: Not Computed

Table A-5a

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Neoplasms

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	1,032	1,117	1,053	1,133
Female	407	356	388	387
Disposition rate per 1000				
Male	1.5	1.6	1.5	1.6
Female	5.5	4.7	5.1	5.0
% Difference	276	192	238	209
Probability	*	*	*	*
Average duration, all cases				
Male	39.1	43.3	40.0	40.2
Female	23.4	23.9	25.2	27.4
% Difference	-40	-45	-37	-32
Probability	*	*	*	*
Average duration, duty cases				
Male	24.7	24.0	18.9	17.5
Female	17.3	17.7	21.1	20.0
% Difference	-30	-26	11	14
Probability	*	*	NS	NS
Average length of stay, all cases				
Male	21.2	20.0	19.1	16.6
Female	10.8	8.5	9.7	9.9
% Difference	-49	-58	-49	-41
Probability	*	*	*	*
Average length of stay, duty cases				
Male	12.9	12.4	9.6	8.6
Female	7.6	6.4	8.0	7.4
% Difference	-41	-49	-17	-14
Probability	*	*	NS	NS
Noneffective rate				
Male	0.2	0.2	0.2	0.2
Female	0.4	0.3	0.4	0.4
% Difference	126	61	113	110
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$

Table A-5b

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Benign Neoplasms

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	596	594	593	613
Female	302	260	292	277
Disposition rate per 1000				
Male	0.8	0.9	0.8	0.9
Female	4.1	3.4	3.8	3.6
% Difference	383	301	352	308
Probability	*	*	*	*
Average duration, all cases				
Male	16.8	15.8	15.6	14.9
Female	18.7	16.9	15.4	20.7
% Difference	11	7	-1	38
Probability	NS	NS	NS	*
Average duration, duty cases				
Male	14.4	13.0	12.8	11.5
Female	15.9	16.8	15.4	20.1
% Difference	10	30	20	74
Probability	NS	*	*	*
Average length of stay, all cases				
Male	8.9	7.3	7.5	6.3
Female	7.3	5.7	5.7	6.0
% Difference	-18	-22	-23	-5
Probability	NS	*	*	NS
Average length of stay, duty cases				
Male	7.6	6.5	6.2	5.4
Female	6.1	5.7	5.7	6.0
% Difference	-20	-12	-8	11
Probability	*	NS	NS	NS
Noneffective rate				
Male	0.0	0.0	0.0	0.0
Female	0.2	0.2	0.2	0.2
% Difference	NC	NC	NC	NC
Probability	NC	NC	NC	NC

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$
NC: Not Computed

Table A-5c

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Benign Neoplasm of Breast

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	0	0	1	2
Female	54	54	63	38
Disposition rate per 1000				
Male	0.0	0.0	0.0	0.0
Female	0.7	0.7	0.8	0.5
% Difference	NC	NC	NC	NC
Probability	NC	NC	NC	NC
Average duration, all cases				
Male	0.0	0.0	1.0	2.0
Female	5.9	6.0	4.6	9.3
% Difference	NC	NC	NC	367
Probability	NC	NC	NC	*
Average duration, duty cases				
Male	0.0	0.0	1.0	2.0
Female	5.9	6.0	4.6	9.3
% Difference	NC	NC	NC	367
Probability	NC	NC	NC	*
Average length of stay, all cases				
Male	0.0	0.0	1.0	2.0
Female	3.0	2.9	2.2	3.2
% Difference	NC	NC	NC	61
Probability	NC	NC	NC	*
Average length of stay, duty cases				
Male	0.0	0.0	1.0	2.0
Female	3.0	2.9	2.2	3.2
% Difference	NC	NC	NC	61
Probability	NC	NC	NC	*
Noneffective rate				
Male	0.0	0.0	0.0	0.0
Female	0.0	0.0	0.0	0.0
% Difference	NC	NC	NC	NC
Probability	NC	NC	NC	NC

*Statistically Significant Difference $p<0.05$
NC: Not Computed

Table A-5d

ADA Female Time Lost to Hospitalization, Worldwide, 1982-1985: Benign Neoplasm of Ovary & Other Female Genital Organs

	CY 82	CY 83	CY 84	CY 85
Dispositions	149	127	138	157
Disposition rate per 1000	2.0	1.7	1.8	2.0
Average duration, all cases	20.8	23.3	21.7	24.2
Average duration, duty cases	20.8	23.3	21.7	24.2
Average length of stay, all cases	7.4	7.0	6.5	6.3
Average length of stay, duty cases	7.4	7.0	6.5	6.3
Noneffective rate	0.1	0.1	0.1	0.1

Table A-6a

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Endocrine, Nutritional and Metabolic Diseases

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	689	639	604	657
Female	141	155	137	171
Disposition rate per 1000				
Male	1.0	0.9	0.9	0.9
Female	1.9	2.0	1.8	2.2
% Difference	95	122	108	135
Probability	*	*	*	*
Average duration, all cases				
Male	30.5	31.9	35.8	40.9
Female	19.4	19.0	19.9	20.1
% Difference	-36	-41	-44	-51
Probability	*	*	*	*
Average duration, duty cases				
Male	20.4	18.0	15.7	17.6
Female	17.8	16.9	17.0	13.0
% Difference	-13	-6	8	-26
Probability	NS	NS	NS	*
Average length of stay, all cases				
Male	15.3	12.7	13.6	12.8
Female	13.2	12.5	13.9	9.8
% Difference	-14	-2	2	-23
Probability	NS	NS	NS	*
Average length of stay, duty cases				
Male	13.7	11.8	11.6	11.3
Female	12.4	11.7	13.8	9.8
% Difference	-10	-1	19	-13
Probability	NS	NS	NS	NS
Noneffective rate				
Male	0.1	0.1	0.1	0.1
Female	0.1	0.1	0.1	0.1
% Difference	24	32	16	16
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$
NC: Not Computed

Table A-6b

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Disorders of Thyroid Gland

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	57	83	57	66
Female	36	50	42	37
Disposition rate per 1000				
Male	0.1	0.1	0.1	0.1
Female	0.5	0.7	0.6	0.5
% Difference	503	452	577	407
Probability	*	*	*	*
Average duration, all cases				
Male	19.1	31.8	21.8	29.1
Female	17.9	25.9	25.7	33.2
% Difference	-7	-19	18	14
Probability	NS	NS	NS	NS
Average duration, duty cases				
Male	18.9	23.9	17.9	25.8
Female	14.3	23.8	23.0	14.7
% Difference	-25	0	28	-43
Probability	NS	NC	NS	NS
Average length of stay, all cases				
Male	11.2	15.6	12.5	10.3
Female	9.2	10.7	15.0	6.0
% Difference	-18	-31	20	-42
Probability	NS	NS	NS	NS
Average length of stay, duty cases				
Male	11.2	14.9	11.0	8.7
Female	6.5	9.3	15.0	6.5
% Difference	-42	-38	36	-25
Probability	*	NS	NS	NS
Noneffective rate				
Male	0.0	0.0	0.0	0.0
Female	0.0	0.0	0.0	0.0
% Difference	NC	NC	NC	NC
Probability	NC	NC	NC	NC

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$
NC: Not Computed

Table A-6c

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Disease of Other Endocrine Glands

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	300	294	258	274
Female	37	25	35	31
Disposition rate per 1000				
Male	0.4	0.4	0.4	0.4
Female	0.5	0.3	0.5	0.4
% Difference	18	-22	25	2
Probability	NS	NS	NS	NC
Average duration, all cases				
Male	43.0	41.5	55.2	62.8
Female	15.4	11.0	19.5	28.5
% Difference	-64	-74	-65	-55
Probability	*	*	*	*
Average duration, duty cases				
Male	23.9	16.8	16.4	19.6
Female	12.7	11.0	11.8	12.5
% Difference	-47	-35	-28	-36
Probability	*	NS	NS	NS
Average length of stay, all cases				
Male	15.1	10.3	11.8	12.7
Female	7.6	8.4	9.7	6.6
% Difference	-50	-19	-18	-48
Probability	*	NS	NS	*
Average length of stay, duty cases				
Male	11.5	8.2	9.8	10.7
Female	6.9	8.4	9.2	6.4
% Difference	-40	2	-6	-40
Probability	*	NS	NS	*
Noneffective rate				
Male	0.1	0.0	0.1	0.1
Female	0.0	0.0	0.0	0.0
% Difference	NC	NC	NC	NC
Probability	NC	NC	NC	NC

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$
NC: Not Computed

Table A-7

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Diseases of the Blood and Blood-Forming Organs

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	261	216	256	247
Female	59	62	66	83
Disposition rate per 1000				
Male	0.4	0.3	0.4	0.4
Female	0.8	0.8	0.9	1.1
% Difference	116	163	137	204
Probability	*	*	*	*
Average duration, all cases				
Male	24.9	19.4	21.2	18.6
Female	17.3	15.6	10.8	10.1
% Difference	-31	-20	-49	-46
Probability	NS	NS	*	*
Average duration, duty cases				
Male	16.1	15.6	13.5	13.7
Female	11.5	12.2	8.7	7.4
% Difference	-28	-22	-36	-46
Probability	NS	NS	*	*
Average length of stay, all cases				
Male	12.0	11.3	9.7	7.5
Female	13.4	9.8	5.7	5.7
% Difference	11	-14	-41	-24
Probability	NS	NS	*	NS
Average length of stay, duty cases				
Male	9.9	9.7	7.8	7.3
Female	7.4	7.3	5.6	5.0
% Difference	-25	-24	-29	-32
Probability	NS	NS	*	*
Noneffective rate				
Male	0.0	0.0	0.0	0.0
Female	0.0	0.0	0.0	0.0
% Difference	NC	NC	NC	NC
Probability	NC	NC	NC	NC

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$
NC: Not Computed

Table A-8a

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Mental Disorders Including Improper Use of Alcohol and Drugs

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	7,214	6,359	6,657	7,541
Female	1,036	1,018	1,056	1,189
Disposition rate per 1000				
Male	10.2	9.1	9.5	10.8
Female	14.0	13.4	13.9	15.4
% Difference	37	47	46	43
Probability	*	*	*	*
Average duration, all cases				
Male	29.3	29.9	30.0	26.2
Female	24.9	25.3	24.9	22.5
% Difference	-15	-16	-17	-14
Probability	*	*	*	*
Average duration, duty cases				
Male	16.7	17.8	19.1	17.6
Female	12.6	13.1	13.6	13.1
% Difference	-25	-27	-29	-26
Probability	*	*	*	*
Average length of stay, all cases				
Male	23.1	23.2	23.2	20.4
Female	18.9	19.6	18.1	16.1
% Difference	-18	-16	-22	-21
Probability	*	*	*	*
Average length of stay, duty cases				
Male	15.1	16.2	17.7	16.4
Female	10.6	11.2	12.1	11.8
% Difference	-30	-31	-32	-28
Probability	*	*	*	*
Noneffective rate				
Male	0.8	0.7	0.8	0.8
Female	1.0	0.9	0.9	1.0
% Difference	16	24	21	22
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$

Table A-8b

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Psychoses

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	1,224	957	850	772
Female	179	159	143	150
Disposition rate per 1000				
Male	1.7	1.4	1.2	1.1
Female	2.4	2.1	1.9	1.9
% Difference	40	52	55	76
Probability	*	*	*	*
Average duration, all cases				
Male	84.9	90.0	89.5	87.7
Female	85.3	84.7	88.1	78.0
% Difference	0	-6	-2	-11
Probability	NC	NS	NS	NS
Average duration, duty cases				
Male	23.6	27.5	26.7	24.0
Female	31.8	26.8	33.2	23.2
% Difference	35	-3	25	-3
Probability	NS	NS	NS	NS
Average length of stay, all cases				
Male	59.9	60.6	56.5	51.8
Female	60.0	62.7	55.7	43.9
% Difference	0	4	-1	-15
Probability	NC	NS	NS	*
Average length of stay, duty cases				
Male	19.8	21.6	22.2	20.4
Female	23.8	21.2	25.8	18.4
% Difference	21	-2	16	-10
Probability	NS	NS	NS	NS
Noneffective rate				
Male	0.4	0.3	0.3	0.3
Female	0.6	0.5	0.5	0.4
% Difference	40	43	52	56
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$
NC: Not Computed

Table A-8c

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Schizophrenia

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	622	425	307	267
Female	86	65	39	45
Disposition rate per 1000				
Male	0.9	0.6	0.4	0.4
Female	1.2	0.9	0.5	0.6
% Difference	32	40	17	52
Probability	*	*	NS	*
Average duration, all cases				
Male	113.9	123.7	119.9	119.6
Female	108.3	91.0	93.2	93.6
% Difference	-5	-26	-22	-22
Probability	NS	*	NS	*
Average duration, duty cases				
Male	42.2	47.7	40.3	38.3
Female	35.3	35.6	38.1	23.5
% Difference	-16	-25	-6	-39
Probability	NS	NS	NS	*
Average length of stay, all cases				
Male	83.2	83.6	76.0	72.2
Female	83.8	66.6	60.3	54.1
% Difference	1	-20	-21	-25
Probability	NS	*	NS	*
Average length of stay, duty cases				
Male	35.3	39.9	35.3	31.3
Female	31.8	30.9	34.3	23.5
% Difference	-10	-23	-3	-25
Probability	NS	NS	NS	NS
Noneffective rate				
Male	0.3	0.2	0.1	0.1
Female	0.3	0.2	0.1	0.1
% Difference	25	3	-9	19
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$

Table A-8d

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Alcoholism

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	2,349	2,036	2,120	1,766
Female	143	131	134	102
Disposition rate per 1000				
Male	3.3	2.9	3.0	2.5
Female	1.9	1.7	1.8	1.3
% Difference	-42	-41	-42	-48
Probability	*	*	*	*
Average duration, all cases				
Male	22.7	25.6	29.4	26.7
Female	16.7	23.0	26.5	26.1
% Difference	-27	-10	-10	-2
Probability	*	NS	NS	NS
Average duration, duty cases				
Male	22.5	25.5	29.1	26.4
Female	16.7	23.0	26.7	26.1
% Difference	-26	-10	-8	-1
Probability	*	NS	NS	NS
Average length of stay, all cases				
Male	21.7	25.1	28.5	26.0
Female	16.5	22.6	26.1	25.6
% Difference	-24	-10	-8	-2
Probability	*	NS	NS	NS
Average length of stay, duty cases				
Male	21.7	25.2	28.5	26.0
Female	16.5	22.6	26.5	25.6
% Difference	-24	-10	-7	-2
Probability	*	NS	NS	NS
Noneffective rate				
Male	0.2	0.2	0.2	0.2
Female	0.1	0.1	0.1	0.1
% Difference	-57	-47	-48	-49
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$

Table A-9

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Disease of the Nervous System and Sense Organs

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	2,516	2,458	2,478	2,466
Female	439	357	431	453
Disposition rate per 1000				
Male	3.6	3.5	3.6	3.5
Female	5.9	4.7	5.7	5.9
% Difference	66	33	60	66
Probability	*	*	*	*
Average duration, all cases				
Male	20.3	24.2	29.4	30.0
Female	22.4	20.4	23.4	26.9
% Difference	10	-16	-21	-10
Probability	NS	NS	*	NS
Average duration, duty cases				
Male	14.1	13.1	13.2	14.0
Female	12.6	11.1	14.0	11.2
% Difference	-11	-15	6	-20
Probability	NS	NS	NS	*
Average length of stay, all cases				
Male	10.1	10.3	9.4	8.7
Female	11.6	8.9	8.4	8.1
% Difference	14	-14	-11	-7
Probability	NS	NS	NS	NS
Average length of stay, duty cases				
Male	7.8	7.1	6.8	6.5
Female	7.7	5.8	7.2	6.0
% Difference	-2	-18	6	-8
Probability	NS	*	NS	NS
Noneffective rate				
Male	0.2	0.2	0.3	0.3
Female	0.4	0.3	0.4	0.4
% Difference	84	12	27	49
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$

Table A-10a

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Diseases of the Circulatory System

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	2,999	2,932	2,893	2,891
Female	191	189	204	173
Disposition rate per 1000				
Male	4.2	4.2	4.1	4.2
Female	2.6	2.5	2.7	2.2
% Difference	-39	-41	-35	-46
Probability	*	*	*	*
Average duration, all cases				
Male	29.4	29.4	28.6	28.6
Female	18.0	18.1	20.1	25.9
% Difference	-39	-38	-30	-9
Probability	*	*	*	NS
Average duration, duty cases				
Male	20.3	16.2	14.8	15.4
Female	16.2	13.2	10.1	12.3
% Difference	-20	-18	-32	-20
Probability	NS	NS	*	NS
Average length of stay, all cases				
Male	11.2	10.3	9.6	8.3
Female	8.7	8.5	7.7	9.4
% Difference	-23	-18	-20	14
Probability	*	NS	NS	NS
Average length of stay, duty cases				
Male	9.1	8.0	7.2	7.2
Female	7.6	7.4	5.4	6.6
% Difference	-16	-8	-26	-8
Probability	NS	NS	*	NS
Noneffective rate				
Male	0.3	0.3	0.3	0.3
Female	0.1	0.1	0.1	0.2
% Difference	-63	-64	-54	-51
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$

Table A-10b

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Cerebrovascular Disease

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	121	108	119	99
Female	3	6	7	4
Disposition rate per 1000				
Male	0.2	0.2	0.2	0.1
Female	0.0	0.1	0.1	0.1
% Difference	NC	-49	-46	-63
Probability	NC	NS	*	*
Average duration, all cases				
Male	59.0	47.2	41.4	49.9
Female	83.7	39.8	20.7	65.3
% Difference	42	-16	-50	31
Probability	NS	NS	NS	NS
Average duration, duty cases				
Male	32.2	21.8	22.1	21.2
Female	81.0	8.8	27.4	39.5
% Difference	NC	-60	24	86
Probability	NC	*	NS	NS
Average length of stay, all cases				
Male	22.4	22.4	18.7	16.9
Female	46.7	14.2	6.6	25.5
% Difference	109	-37	-65	51
Probability	NS	NS	*	NS
Average length of stay, duty cases				
Male	15.3	10.8	13.8	10.2
Female	56.0	6.0	9.0	26.0
% Difference	NC	-45	-35	155
Probability	NC	NS	NS	*
Noneffective rate				
Male	0.0	0.0	0.0	0.0
Female	0.0	0.0	0.0	0.0
% Difference	NC	NC	NC	NC
Probability	NC	NC	NC	NC

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$
NC: Not Computed

Table A-10c

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Diseases of Arteries, Arterials and Capillaries

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	114	125	112	102
Female	14	6	6	13
Disposition rate per 1000				
Male	0.2	0.2	0.2	0.1
Female	0.2	0.1	0.1	0.2
% Difference	17	-56	-51	15
Probability	NS	NS	NS	NS
Average duration, all cases				
Male	37.8	39.5	40.8	47.8
Female	25.9	15.0	32.5	109.8
% Difference	-32	-62	-20	130
Probability	NS	*	NS	NS
Average duration, duty cases				
Male	21.8	20.6	18.9	21.0
Female	13.8	15.0	13.0	43.6
% Difference	-37	-27	-31	108
Probability	NS	NS	NS	NS
Average length of stay, all cases				
Male	18.6	16.9	16.4	11.3
Female	19.9	11.5	9.0	23.8
% Difference	7	-32	-45	111
Probability	NS	NS	NS	*
Average length of stay, duty cases				
Male	12.4	12.5	10.6	10.1
Female	10.8	11.5	5.7	15.8
% Difference	-12	-8	-46	57
Probability	NS	NS	NS	NS
Noneffective rate				
Male	0.0	0.0	0.0	0.0
Female	0.0	0.0	0.0	0.1
% Difference	NC	NC	NC	NC
Probability	NC	NC	NC	NC

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$
NC: Not Computed

Table A-10d

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Phlebitis and Thrombophlebitis

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	139	134	93	117
Female	20	25	16	24
Disposition rate per 1000				
Male	0.2	0.2	0.1	0.2
Female	0.3	0.3	0.2	0.3
% Difference	37	71	58	85
Probability	NS	*	NS	*
Average duration, all cases				
Male	23.7	21.4	15.8	21.1
Female	31.9	15.2	16.2	28.2
% Difference	34	-29	2	34
Probability	NS	NS	NC	NS
Average duration, duty cases				
Male	21.2	14.4	13.9	12.7
Female	29.6	11.4	7.9	10.0
% Difference	40	-21	-44	-21
Probability	NS	NS	*	NS
Average length of stay, all cases				
Male	12.6	10.0	9.8	9.6
Female	7.7	7.2	13.3	6.8
% Difference	-39	-27	37	-30
Probability	*	NS	NS	NS
Average length of stay, duty cases				
Male	10.6	9.5	9.9	9.3
Female	7.6	7.5	6.1	6.0
% Difference	-28	-21	-39	-36
Probability	NS	NS	*	*
Noneffective rate				
Male	0.0	0.0	0.0	0.0
Female	0.0	0.0	0.0	0.0
% Difference	NC	NC	NC	NC
Probability	NC	NC	NC	NC

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$
NC: Not Computed

Table A-11a

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Diseases of the Respiratory System

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	17,088	16,572	12,984	10,782
Female	2,683	2,118	1,929	1,567
Disposition rate per 1000				
Male	24.2	23.8	18.6	15.5
Female	36.3	27.9	25.4	20.4
% Difference	50	17	36	31
Probability	*	*	*	*
Average duration, all cases				
Male	4.7	4.8	5.6	6.5
Female	4.6	5.0	5.2	6.8
% Difference	-2	3	-7	5
Probability	NS	NS	NS	NS
Average duration, duty cases				
Male	4.5	4.5	4.9	5.0
Female	4.5	4.6	4.7	4.9
% Difference	-1	1	-4	-2
Probability	NS	NS	NS	NS
Average length of stay, all cases				
Male	3.6	3.7	3.9	3.7
Female	3.5	3.6	3.6	3.4
% Difference	-4	-4	-8	-7
Probability	NS	NS	*	*
Average length of stay, duty cases				
Male	3.5	3.7	3.7	3.6
Female	3.4	3.4	3.5	3.4
% Difference	-3	-7	-6	-4
Probability	NS	*	*	NS
Noneffective rate				
Male	0.3	0.3	0.3	0.3
Female	0.5	0.4	0.4	0.4
% Difference	47	21	27	38
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$

Table A-11b

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Acute Respiratory Infections Except Influenza

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	10,706	10,713	7,291	5,873
Female	1,801	1,404	1,231	877
Disposition rate per 1000				
Male	15.2	15.4	10.4	8.4
Female	24.3	18.5	16.2	11.4
% Difference	60	20	55	35
Probability	*	*	*	*
Average duration, all cases				
Male	3.0	3.2	3.0	3.0
Female	3.0	3.1	3.3	3.1
% Difference	0	-2	9	2
Probability	NS	NS	*	NS
Average duration, duty cases				
Male	3.0	3.2	3.0	3.0
Female	3.0	3.1	3.3	3.1
% Difference	1	-3	9	1
Probability	NS	NS	*	NS
Average length of stay, all cases				
Male	2.8	3.1	2.9	2.9
Female	2.8	3.0	3.1	2.9
% Difference	-1	-5	5	1
Probability	NS	*	*	NS
Average length of stay, duty cases				
Male	2.8	3.1	2.9	2.9
Female	2.8	2.9	3.1	2.9
% Difference	-1	-6	5	1
Probability	NS	*	*	NS
Noneffective rate				
Male	0.1	0.1	0.1	0.1
Female	0.2	0.2	0 1	0.1
% Difference	61	17	69	37
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$
NS = No Significant Difference $p>0.05$

Table A-12

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Diseases of the Digestive System

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	8,616	8,704	9,261	8,883
Female	1,272	1,398	1,407	1,489
Disposition rate per 1000				
Male	12.2	12.5	13.3	12.8
Female	17.2	18.4	18.5	19.3
% Difference	41	47	40	52
Probability	*	*	*	*
Average duration, all cases				
Male	14.2	13.1	13.1	13.0
Female	12.7	11.8	10.8	11.1
% Difference	-10	-10	-17	-15
Probability	*	*	*	*
Average duration, duty cases				
Male	13.4	12.3	11.9	12.0
Female	11.8	11.2	10.5	10.1
% Difference	-12	-9	-12	-16
Probability	*	*	*	*
Average length of stay, all cases				
Male	6.5	5.8	5.6	5.3
Female	6.0	5.6	5.4	5.0
% Difference	-8	-4	-4	-5
Probability	NS	NS	NS	NS
Average length of stay, duty cases				
Male	6.2	5.6	5.3	5.2
Female	5.7	5.5	5.3	4.7
% Difference	-8	-1	-2	-9
Probability	*	NS	NS	*
Noneffective rate				
Male	0.5	0.4	0.5	0.5
Female	0.6	0.6	0.5	0.6
% Difference	26	33	15	29
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$

Table A-13a

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Diseases of the Genitourinary System

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	3,174	2,847	3,026	2,911
Female	2,784	2,749	2,797	3,011
Disposition rate per 1000				
Male	4.5	4.1	4.3	4.2
Female	37.6	36.2	36.8	39.1
% Difference	737	784	749	835
Probability	*	*	*	*
Average duration, all cases				
Male	10.0	11.2	11.2	10.9
Female	10.5	10.6	9.8	10.4
% Difference	5	-5	-13	-5
Probability	NS	NS	*	NS
Average duration, duty cases				
Male	9.4	9.6	9.5	9.4
Female	10.4	10.3	9.6	10.2
% Difference	11	7	1	9
Probability	*	NS	NS	*
Average length of stay, all cases				
Male	5.7	6.0	5.4	5.3
Female	4.9	4.9	4.5	4.5
% Difference	-15	-19	-16	-16
Probability	*	*	*	*
Average length of stay, duty cases				
Male	5.6	5.4	5.0	5.0
Female	4.9	4.7	4.5	4.5
% Difference	-13	-13	-9	-10
Probability	*	*	*	*
Noneffective rate				
Male	0.1	0.1	0.1	0.1
Female	1.1	1.1	1.0	1.1
% Difference	780	738	640	791
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$

Table A-13b

ADA Male Time Lost to Hospitalization, Worldwide 1982-1985: Diseases of Male Genital Organs

	CY 82	CY 83	CY 84	CY 85
Dispositions	1,901	1,608	1,741	1,679
Disposition rate per 1000	2.7	2.3	2.5	2.4
Average duration, all cases	8.9	9.2	10.4	9.8
Average duration, duty cases	8.8	8.8	9.5	9.2
Average length of stay, all cases	4.9	4.5	4.5	4.6
Average length of stay, duty cases	4.8	4.4	4.5	4.5
Noneffective rate	0.1	0.1	0.1	0.1

Table A-13c

ADA Female Time Lost to Hospitalization, Worldwide 1982-1985: Diseases of Female Genitalia

	CY 82	CY 83	CY 84	CY 85
Dispositions	2,252	2,237	2,289	2,453
Disposition rate per 1000	30.4	29.4	30.1	31.9
Average duration, all cases	11.0	11.4	10.1	11.0
Average duration, duty cases	10.9	10.8	9.9	10.7
Average length of stay, all cases	4.9	4.7	4.4	4.5
Average length of stay, duty cases	4.9	4.7	4.4	4.5
Noneffective rate	0.9	0.9	0.8	1.0

Table A-13d

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide 1982-1985: Diseases of the Genitourinary System Excluding Gender Specific Diagnoses

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	1,273	1,239	1,285	1,232
Female	532	512	508	558
Disposition rate per 1000				
Male	1.8	1.8	1.8	1.8
Female	7.2	6.7	6.7	7.2
% Difference	299	278	263	309
Probability	*	*	*	*
Average duration, all cases				
Male	11.7	13.8	12.4	12.4
Female	8.5	8.9	8.7	7.9
% Difference	-27	-36	-30	-36
Probability	*	*	*	*
Average duration, duty cases				
Male	10.4	10.7	9.4	9.6
Female	8.3	7.8	8.1	7.6
% Difference	-20	-27	-14	-20
Probability	*	*	*	*
Average length of stay, all cases				
Male	7.0	8.0	6.6	6.3
Female	4.9	5.5	5.0	4.6
% Difference	-31	-31	-24	-27
Probability	*	*	*	*
Average length of stay, duty cases				
Male	6.7	6.7	5.7	5.6
Female	4.9	4.8	4.9	4.6
% Difference	-27	-28	-13	-19
Probability	*	*	*	*
Noneffective rate				
Male	0.1	0.1	0.1	0.1
Female	0.2	0.2	0.2	0.2
% Difference	189	143	154	161
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$

Table A-14a

ADA Female Time Lost to Hospitalization, Worldwide 1982-1985: Complications of Pregnancy, Childbirth, and the Puerperium, All Cases

	CY 82	CY 83	CY 84	CY 85
Dispositions	7,767	8,404	8,347	8,459
Disposition rate per 1000	105.0	110.6	109.8	109.9
Average duration, all cases	17.1	17.2	16.1	15.6
Average duration, duty cases	17.1	17.1	16.1	15.5
Average length of stay, all cases	3.9	4.0	3.9	3.9
Average length of stay, duty cases	3.9	3.9	3.9	3.9
Noneffective rate	4.9	5.2	4.8	4.7

Table A-14b

Complications of Pregnancy, Childbirth and the Puerperium, Percent of Total ADA Female Dispositions

CY 82	CY 8	CY 84	CY 85
34%	37%	36%	35%

Table A-14c

Complications of Pregnancy, Childbirth, and the Puerperium, Percent of Total ADA Female Noneffectiveness

CY 82	CY 83	CY 84	CY 85
41%	43%	40%	37%

Table 14d

ADA Female Time Lost to Hospitalization, Worldwide 1982-1985: Complications of Pregnancy

	CY 82	CY 83	CY 84	CY 85
Dispositions	1,873	2,200	2,463	2,633
Disposition rate per 1000	25.3	28.9	32.4	34.2
Average duration, all cases	12.8	14.6	12.7	12.7
Average duration, duty cases	12.7	14.6	12.7	12.4
Average length of stay, all cases	4.6	4.9	4.7	4.5
Average length of stay, duty cases	4.6	4.9	4.7	4.5
Noneffective rate	0.9	1.2	1.1	1.2

Table A-14e

ADA Female Time Lost to Hospitalization, Worldwide 1982-1985: Abortions

	CY 82	CY 83	CY 84	CY 85
Dispositions	737	781	710	684
Disposition rate per 1000	9.9	10.3	9.3	8.9
Average duration, all cases	3.5	3.4	3.6	3.9
Average duration, duty cases	3.5	3.4	3.6	3.9
Average length of stay, all cases	1.9	1.9	1.8	2.0
Average length of stay, duty cases	1.9	1.9	1.8	2.0
Noneffective rate	0.1	0.1	0.1	0.1

Table A-14f

ADA Female Time Lost to Hospitalization, Worldwide 1982-1985: Spontaneous Abortions

	CY 82	CY 83	CY 84	CY 85
Dispositions	708	757	698	675
Disposition rate per 1000	9.6	10.0	9.2	8.8
Average duration, all cases	3.5	3.4	3.6	3.9
Average duration, duty cases	3.5	3.4	3.6	3.9
Average length of stay, all cases	1.8	1.9	1.8	2.0
Average length of stay, duty cases	1.8	1.9	1.8	2.0
Noneffective rate	0.1	0.1	0.1	0.1

Table A-14g

ADA Female Time Lost to Hospitalization, Worldwide 1982-1985: Uncomplicated Delivery

	CY 82	CY 83	CY 84	CY 85
Dispositions	1,708	1,737	1,465	1,451
Disposition rate per 1000	23.1	22.9	19.3	18.8
Average duration, all cases	20.9	19.9	17.9	18.4
Average duration, duty cases	20.9	19.6	17.9	18.4
Average length of stay, all	2.8	2.8	2.8	3.0
Average length of stay, duty cases	2.8	2.8	2.8	3.0
Noneffective rate	1.3	1.2	0.9	1.0

Table A-14h

ADA Female Time Lost to Hospitalization, Worldwide 1982-1985: Complicated Delivery

	CY 82	CY 83	CY 84	CY 85
Dispositions	3,413	3,652	3,643	3,642
Disposition rate per 1000	46.1	48.1	47.9	47.3
Average duration, all cases	20.6	20.5	20.0	18.8
Average duration, duty cases	20.6	20.4	20.0	18.8
Average length of stay, all cases	4.5	4.4	4.1	4.1
Average length of stay, duty cases	4.5	4.3	4.1	4.1
Noneffective rate	2.6	2.7	2.6	2.4

Table A-14i

Complications of Pregnancy, Childbirth, and the Puerperium, Percent of Specific Diagnosis Subgroups Contributing to Total ADA Female Disposition Rate

Category	Calendar Year			
	82	83	84	85
Complications of pregnancy	24%	26%	30%	31%
Abortions (all)	9%	9%	8%	8%
Abortions (spontaneous)	9%	9%	8%	8%
Delivery, uncomplicated	22%	21%	18%	17%
Delivery, complicated	44%	43%	43%	43%
Other	1%	1%	1%	1%

Table A-14j

Complications of Pregnancy, Childbirth, and the Puerperium, Percent of Specific Diagnosis Subgroups Contributing to Total ADA Female Noneffective Rate

Category	Calendar Year		
	82	83	84
Complications of pregnancy	18%	23%	[illegible]
Abortions (all)	2%	2%	[illegible]
Abortions (spontaneous)	2%	2%	[illegible]
Delivery, uncomplicated	27%	[illegible]	
Delivery, complicated	53%	[illegible]	

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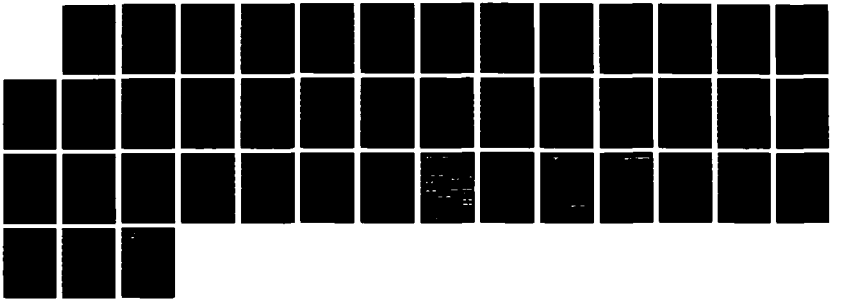


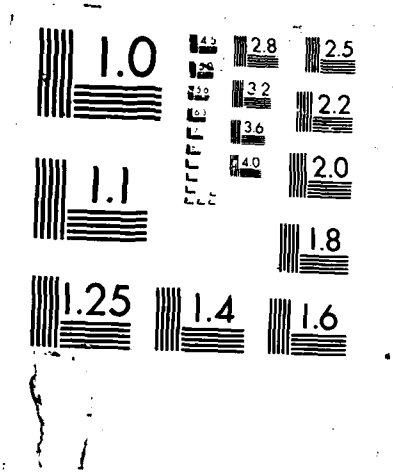

1.0
2.8
2.5
3.2
2.2
3.6
4.0
2.0
1.1
1.8
1.25
1.4
1.6

Table A-15

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide,

1982-1985: Diseases of the Skin and Subcutaneous Tissue

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	2,938	2,835	2,811	2,794
Female	386	395	335	357
Disposition rate per 1000				
Male	4.2	4.1	4.0	4.0
Female	5.2	5.2	4.4	4.6
% Difference	25	28	9	15
Probability	*	*	*	*
Average duration, all cases				
Male	10.8	11.7	10.3	10.9
Female	12.2	12.7	12.9	11.8
% Difference	12	9	26	7
Probability	NS	NS	NS	NS
Average duration, duty cases				
Male	10.3	10.3	9.2	9.3
Female	11.2	11.9	10.8	9.7
% Difference	9	16	17	3
Probability	NS	NS	*	NS
Average length of stay, all cases				
Male	6.9	6.7	6.0	6.2
Female	7.7	6.3	7.1	6.2
% Difference	12	-6	18	0
Probability	NS	NS	NS	NS
Average length of stay, duty cases				
Male	6.8	6.2	5.9	5.9
Female	7.2	6.2	6.3	5.0
% Difference	6	0	7	-14
Probability	NS	NS	NS	*
Noneffective rate				
Male	0.1	0.1	0.1	0.1
Female	0.2	0.2	0.2	0.1
% Difference	41	39	37	24
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$

Table A-16a

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Diseases of the Musculoskeletal System and Connective Tissue

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	8,880	9,333	9,890	9,848
Female	1,205	1,321	1,454	1,523
Disposition rate per 1000				
Male	12.6	13.4	14.2	14.1
Female	16.3	17.4	19.1	19.8
% Difference	29	30	35	40
Probability	*	*	*	*
Average duration, all cases				
Male	26.2	27.4	28.4	28.5
Female	22.7	24.0	26.5	31.6
% Difference	-14	-13	-7	11
Probability	*	*	NS	NS
Average duration, duty cases				
Male	21.1	19.7	18.3	16.3
Female	17.3	17.4	17.2	15.9
% Difference	-18	-12	-6	-2
Probability	*	*	NS	NS
Average length of stay, all cases				
Male	11.6	11.1	10.6	9.3
Female	10.2	9.0	9.3	8.6
% Difference	-12	-19	-12	-8
Probability	*	*	*	NS
Average length of stay, duty cases				
Male	10.5	9.8	9.2	8.0
Female	9.0	7.9	7.8	7.2
% Difference	-14	-19	-16	-10
Probability	*	*	*	*
Noneffective rate				
Male	0.9	1.0	1.1	1.1
Female	1.0	1.1	1.4	1.7
% Difference	12	13	26	55
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$

Table A-16b

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Other Disorders of Synovium, Tendon and Bursa

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	541	589	675	639
Female	115	134	148	136
Disposition rate per 1000				
Male	0.8	0.8	1.0	0.9
Female	1.6	1.8	1.9	1.8
% Difference	103	108	101	92
Probability	*	*	*	*
Average duration, all cases				
Male	12.6	12.2	12.1	11.3
Female	16.4	9.6	10.3	10.7
% Difference	31	-21	-15	-5
Probability	NS	NS	NS	NS
Average duration, duty cases				
Male	12.2	12.1	10.8	9.9
Female	14.9	9.6	10.3	7.7
% Difference	22	-21	-5	-22
Probability	NS	NS	NS	*
Average length of stay, all cases				
Male	5.9	6.4	6.4	4.8
Female	8.5	4.2	4.3	4.0
% Difference	44	-35	-33	-17
Probability	NS	*	*	NS
Average length of stay, duty cases				
Male	5.9	6.5	6.0	4.6
Female	8.0	4.2	4.3	3.9
% Difference	35	-34	-29	-16
Probability	NS	*	*	NS
Noneffective rate				
Male	0.0	0.0	0.0	0.0
Female	0.1	0.0	0.1	0.1
% Difference	NC	NC	NC	NC
Probability	NC	NC	NC	NC

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$
NC: Not Computed

Table A-16c

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Bunion

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	141	112	127	139
Female	49	52	64	52
Disposition rate per 1000				
Male	0.2	0.2	0.2	0.2
Female	0.7	0.7	0.8	0.7
% Difference	232	325	363	238
Probability	*	*	*	*
Average duration, all cases				
Male	14.7	14.0	13.0	12.5
Female	19.2	18.1	14.3	12.5
% Difference	31	30	10	0
Probability	NS	NS	NS	NC
Average duration, duty cases				
Male	13.9	14.0	13.0	12.5
Female	19.2	18.1	14.3	12.5
% Difference	39	30	10	0
Probability	*	NS	NS	NC
Average length of stay, all cases				
Male	5.1	5.2	4.9	4.6
Female	7.2	5.4	4.3	4.3
% Difference	40	4	-12	-7
Probability	NS	NS	NS	NS
Average length of stay, duty cases				
Male	5.0	5.2	4.9	4.6
Female	7.2	5.4	4.3	4.3
% Difference	44	4	-12	-8
Probability	NS	NS	NS	NS
Noneffective rate				
Male	0.0	0.0	0.0	0.0
Female	0.0	0.0	0.0	0.0
% Difference	NC	NC	NC	NC
Probability	NC	NC	NC	NC

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$
NC: Not Computed

Table A-16d

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Acquired Deformities of Toe

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	158	245	206	236
Female	65	116	141	113
Disposition rate per 1000				
Male	0.2	0.4	0.3	0.3
Female	0.9	1.5	1.9	1.5
% Difference	292	334	529	333
Probability	*	*	*	*
Average duration, all cases				
Male	15.6	19.3	20.2	14.0
Female	16.9	18.0	20.2	13.1
% Difference	9	-7	0	-7
Probability	NS	NS	NC	NS
Average duration, duty cases				
Male	15.6	18.0	20.0	12.9
Female	16.9	18.0	20.3	13.1
% Difference	9	0	1	1
Probability	NS	NC	NS	NS
Average length of stay, all cases				
Male	5.5	4.9	5.3	4.4
Female	5.0	4.6	4.7	4.0
% Difference	-8	-7	-11	-8
Probability	NS	NS	NS	NS
Average length of stay, duty cases				
Male	5.5	4.9	5.3	4.4
Female	5.0	4.6	4.7	4.0
% Difference	-8	-7	-11	-9
Probability	NS	NS	NS	NS
Noneffective rate				
Male	0.0	0.0	0.0	0.0
Female	0.0	0.1	0.1	0.1
% Difference	NC	NC	NC	NC
Probability	NC	NC	NC	NC

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$
NC: Not Computed

Table A-16e

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Acquired Deformities of Toe - Hallux Valgus (Acquired)

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	156	240	202	228
Female	63	115	138	110
Disposition rate per 1000				
Male	0.2	0.3	0.3	0.3
Female	0.9	1.5	1.8	1.4
% Difference	285	339	527	336
Probability	*	*	*	*
Average duration, all cases				
Male	15.7	19.3	20.1	13.8
Female	16.9	18.1	20.3	13.1
% Difference	8	-6	1	-5
Probability	NS	NS	NS	NS
Average duration, duty cases				
Male	15.7	18.0	20.0	12.6
Female	16.9	18.1	20.4	13.1
% Difference	8	1	2	4
Probability	NS	NS	NS	NS
Average length of stay, all cases				
Male	5.5	4.9	5.2	4.3
Female	5.1	4.5	4.7	4.0
% Difference	-7	-8	-10	-7
Probability	NS	NS	NS	NS
Average length of stay, duty cases				
Male	5.5	4.9	5.3	4.4
Female	5.1	4.5	4.7	4.0
% Difference	-7	-7	-10	-8
Probability	NS	NS	NS	NS
Noneffective rate				
Male	0.0	0.0	0.0	0.0
Female	0.0	0.1	0.1	0.1
% Difference	NC	NC	NC	NC
Probability	NC	NC	NC	NC

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$
NC: Not Computed

Table A-16f

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Acquired Deformities of Toe - Hallux Varus (Acquired)

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	2	5	4	8
Female	2	1	3	3
Disposition rate per 1000				
Male	0.0	0.0	0.0	0.0
Female	0.0	0.0	0.0	0.0
% Difference	NC	NC	NC	NC
Probability	NC	NC	NC	NC
Average duration, all cases				
Male	4.5	19.4	21.0	22.1
Female	17.0	5.0	13.3	11.7
% Difference	278	NC	-37	-47
Probability	NS	NC	NS	NS
Average duration, duty cases				
Male	4.5	19.4	21.0	22.1
Female	17.0	5.0	13.3	11.7
% Difference	278	NC	-37	-47
Probability	NS	NC	NS	NS
Average length of stay, all cases				
Male	4.5	4.8	7.0	5.6
Female	3.0	5.0	4.0	3.3
% Difference	-33	NC	-43	-41
Probability	NS	NC	NS	NS
Average length of stay, duty cases				
Male	4.5	4.8	7.0	5.6
Female	3.0	5.0	4.0	3.3
% Difference	-33	NC	-43	-41
Probability	NS	NC	NS	NS
Noneffective rate				
Male	0.0	0.0	0.0	0.0
Female	0.0	0.0	0.0	0.0
% Difference	NC	NC	NC	NC
Probability	NC	NC	NC	NC

NS: No Significant Difference $p>0.05$
NC: Not Computed

Table A-17

Gender Differentials for ADA personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Congenital Anomalies

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	443	453	467	439
Female	91	70	87	91
Disposition rate per 1000				
Male	0.6	0.7	0.7	0.6
Female	1.2	0.9	1.1	1.2
% Difference	96	42	71	87
Probability	*	*	*	*
Average duration, all cases				
Male	29.7	27.7	33.0	31.8
Female	26.9	22.7	24.9	18.5
% Difference	-9	-18	-24	-42
Probability	NS	NS	NS	*
Average duration, duty cases				
Male	23.5	21.8	20.1	16.9
Female	16.2	20.7	19.7	15.3
% Difference	-31	-5	-2	-9
Probability	*	NS	NS	NS
Average length of stay, all cases				
Male	15.2	12.4	12.6	10.7
Female	12.2	8.0	11.9	7.3
% Difference	-19	-35	-5	-32
Probability	NS	*	NS	*
Average length of stay, duty cases				
Male	12.3	11.0	9.3	8.5
Female	7.9	7.8	9.3	7.2
% Difference	-36	-29	1	-15
Probability	*	NS	NS	NS
Noneffective rate				
Male	0.1	0.0	0.1	0.1
Female	0.1	0.1	0.1	0.1
% Difference	78	NC	29	9
Probability	*	NC	*	*

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$
NC: Not Computed

Table A-18

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Symptoms and Ill Defined Conditions

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	2,940	3,042	2,590	2,454
Female	704	675	641	617
Disposition rate per 1000				
Male	4.2	4.4	3.7	3.5
Female	9.5	8.9	8.4	8.0
% Difference	128	103	127	127
Probability	*	*	*	*
Average duration, all cases				
Male	7.3	6.5	6.4	6.0
Female	7.3	8.6	7.1	7.0
% Difference	0	32	12	16
Probability	NC	*	NS	NS
Average duration, duty cases				
Male	6.9	6.0	5.7	5.3
Female	7.2	6.7	5.7	6.3
% Difference	5	10	0	20
Probability	NS	NS	NC	NS
Average length of stay, all cases				
Male	5.3	4.8	4.4	4.0
Female	4.9	5.6	4.5	4.3
% Difference	-8	17	1	7
Probability	NS	NS	NS	NS
Average length of stay, duty cases				
Male	5.2	4.8	4.3	3.8
Female	4.9	5.0	4.0	3.9
% Difference	-6	5	-7	1
Probability	NS	NS	NS	NS
Noneffective rate				
Male	0.1	0.1	0.1	0.1
Female	0.2	0.2	0.2	0.2
% Difference	129	169	154	164
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$

Table A-19a

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Nonbattle Injuries

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	16,993	15,639	15,493	16,331
Female	1,501	1,414	1,415	1,620
Disposition rate per 1000				
Male	24.1	22.5	22.2	23.5
Female	20.3	18.6	18.6	21.0
% Difference	-16	-17	-16	-10
Probability	*	*	*	*
Average duration, all cases				
Male	19.6	21.1	19.5	18.1
Female	13.8	15.4	15.0	15.4
% Difference	-29	-27	-23	-15
Probability	*	*	*	*
Average duration, duty cases				
Male	15.5	14.9	14.0	13.0
Female	11.0	11.8	11.0	10.0
% Difference	-29	-21	-21	-23
Probability	*	*	*	*
Average length of stay, all cases				
Male	10.5	10.3	9.6	8.6
Female	7.9	8.1	7.2	7.3
% Difference	-25	-22	-25	-15
Probability	*	*	*	*
Average length of stay, duty cases				
Male	8.8	8.2	7.7	7.1
Female	6.6	6.4	5.9	5.7
% Difference	-26	-22	-23	-20
Probability	*	*	*	*
Noneffective rate				
Male	1.3	1.3	1.2	1.2
Female	0.8	0.8	0.8	0.9
% Difference	-41	-39	-35	-24
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$

Table A-19b

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Fractures

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	4,558	4,246	4,146	4,077
Female	280	268	228	225
Disposition rate per 1000				
Male	6.5	6.1	5.9	5.9
Female	3.8	3.5	3.0	3.3
% Difference	-41	-42	-49	-43
Probability	*	*	*	*
Average duration, all cases				
Male	34.4	39.1	34.5	33.1
Female	33.1	43.1	45.8	42.8
% Difference	-4	10	33	29
Probability	NS	NS	NS	NS
Average duration, duty cases				
Male	27.4	27.0	24.0	23.4
Female	26.3	28.0	27.1	25.2
% Difference	-4	4	13	8
Probability	NS	NS	NS	NS
Average length of stay, all cases				
Male	17.3	17.5	15.9	14.2
Female	17.2	19.4	17.9	16.8
% Difference	0	11	13	18
Probability	NS	NS	NS	NS
Average length of stay, duty cases				
Male	14.8	13.9	12.3	11.5
Female	13.8	12.5	11.5	10.8
% Difference	-7	-10	-7	-6
Probability	NS	NS	NS	NS
Noneffective rate				
Male	0.6	0.7	0.6	0.5
Female	0.3	0.4	0.4	0.4
% Difference	-44	-36	-33	-27
Probability	*	*	*	*

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$

Table A-19c

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Dislocations

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	886	750	755	734
Female	51	57	56	33
Disposition rate per 1000				
Male	1.3	1.1	1.1	1.1
Female	0.7	0.8	0.7	0.4
% Difference	-45	-30	-32	-59
Probability	*	*	*	*
Average duration, all cases				
Male	26.1	22.4	26.2	23.0
Female	24.7	19.1	24.0	26.5
% Difference	-5	-15	-8	16
Probability	NS	NS	NS	NS
Average duration, duty cases				
Male	21.7	17.7	20.6	19.2
Female	24.7	19.1	21.8	18.1
% Difference	14	8	6	-6
Probability	NS	NS	NS	NS
Average length of stay, all cases				
Male	14.0	10.1	11.9	9.8
Female	10.7	9.1	12.3	10.8
% Difference	-24	-11	4	10
Probability	NS	NS	NS	NS
Average length of stay, duty cases				
Male	12.1	8.9	9.7	8.6
Female	10.7	9.1	10.4	9.3
% Difference	-12	1	8	7
Probability	NS	NS	NS	NS
Noneffective rate				
Male	0.1	0.1	0.1	0.1
Female	0.0	0.0	0.0	0.0
% Difference	NC	NC	NC	NC
Probability	NC	NC	NC	NC

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$
NC: Not Computed

Table A-19d

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Lacerations and Open Wounds

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	2,587	2,397	2,184	2,332
Female	118	116	123	121
Disposition rate per 1000				
Male	3.7	3.4	3.1	3.4
Female	1.6	1.5	1.6	1.6
% Difference	-56	-56	-48	-53
Probability	*	*	*	*
Average duration, all cases				
Male	16.8	17.9	15.7	16.3
Female	11.4	11.7	14.4	14.8
% Difference	-32	-35	-8	-9
Probability	NS	*	NS	NS
Average duration, duty cases				
Male	12.8	12.3	12.1	11.7
Female	8.8	11.7	14.4	8.8
% Difference	-31	-5	19	-25
Probability	*	NS	NS	*
Average length of stay, all cases				
Male	9.3	9.7	8.4	8.0
Female	6.2	7.2	7.7	6.8
% Difference	-33	-26	-8	-15
Probability	*	*	NS	NS
Average length of stay, duty cases				
Male	7.3	7.2	6.9	6.8
Female	5.0	7.2	7.7	5.5
% Difference	-31	-1	11	-18
Probability	*	NS	NS	NS
Noneffective rate				
Male	0.2	0.2	0.1	0.1
Female	0.0	0.0	0.1	0.1
% Difference	NC	NC	-53	-57
Probability	NC	NC	*	*

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$
NC: Not Computed

Table A-19e

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Adverse Effect of Chemical Substances

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	882	831	1,015	1,157
Female	233	241	236	281
Disposition rate per 1000				
Male	1.2	1.2	1.5	1.7
Female	3.1	3.2	3.1	3.6
% Difference	152	166	114	120
Probability	*	*	*	*
Average duration, all cases				
Male	5.5	5.3	6.0	6.5
Female	6.5	5.1	4.2	5.6
% Difference	18	-4	-31	-13
Probability	NS	NS	*	NS
Average duration, duty cases				
Male	5.0	4.4	4.5	5.5
Female	4.5	5.1	4.2	5.1
% Difference	-11	15	-8	-8
Probability	NS	NS	NS	NS
Average length of stay, all cases				
Male	4.2	4.5	4.8	5.6
Female	5.4	4.8	3.8	5.2
% Difference	28	6	-21	-7
Probability	NS	NS	NS	NS
Average length of stay, duty cases				
Male	3.9	3.9	4.0	5.1
Female	4.1	4.8	3.8	4.8
% Difference	5	22	-6	-6
Probability	NS	NS	NS	NS
Noneffective rate				
Male	0.0	0.0	0.0	0.0
Female	0.1	0.0	0.0	0.1
% Difference	NC	NC	NC	NC
Probability	NC	NC	NC	NC

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$
NC: Not Computed

Table A-19f

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Complications of Surgical Care

	CY 82	CY 83	CY 84	CY 85
Dispositions				
Male	349	329	355	341
Female	68	76	62	56
Disposition rate per 1000				
Male	0.5	0.5	0.5	0.5
Female	0.9	1.0	0.8	0.7
% Difference	86	112	60	48
Probability	*	*	*	*
Average duration, all cases				
Male	12.2	17.2	14.4	15.1
Female	10.8	10.9	9.4	11.9
% Difference	-12	-37	-35	-21
Probability	NS	*	*	*
Average duration, duty cases				
Male	12.2	15.8	12.5	14.2
Female	10.8	9.8	9.4	12.1
% Difference	-12	-38	-25	-14
Probability	NS	*	NS	NS
Average length of stay, all cases				
Male	7.2	9.7	8.2	8.6
Female	6.2	5.4	5.5	5.7
% Difference	-14	-44	-32	-34
Probability	NS	*	*	*
Average length of stay, duty cases				
Male	7.2	9.0	7.8	8.5
Female	6.2	5.0	5.5	5.7
% Difference	-14	-44	-29	-32
Probability	NS	*	*	*
Noneffective rate				
Male	0.0	0.0	0.0	0.0
Female	0.0	0.0	0.0	0.0
% Difference	NC	NC	NC	NC
Probability	NC	NC	NC	NC

*Statistically Significant Difference $p<0.05$
NS: No Significant Difference $p>0.05$
NC: Not Computed

Table A-20

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Percent of Dispositions [1] By Causative Agent

	CY 82		CY 83		CY 84		CY 85	
Causative Agent	M	F	M	F	M	F	M	F
Air transport or spacecraft accidents	2.2	0.4	2.7	0.8	2.5	1.1	3.1	1.4
Motor vehicle accidents	20.9	16.1	21.0	15.7	20.4	16.4	19.0	13.2
Athletics/sports/ physical training	11.9	7.I	12.6	7.0	12.8	5.7	12.6	7.2
Complications, prophylactic inoculation	1.1	3.1	0.8	1.5	0.6	0.9	1.2	1.9
Complications, other medical procedures	5.3	16.8	5.6	16.4	6.3	16.0	5.8	13.8
Small arms weapons [2]	1.7	0.4	1.4	0.5	1.4	0.5	1.1	0.7
Other guns, explosives, etc. [3]	1.4	0.1	1.6	0.3	1.2	0.3	1.5	0.2
Cutting/piercing instruments/objects	5.4	3.7	5.6	3.9	5.2	3.6	5.7	3.8
Falling/projected objects/missiles	1.3	0.5	1.6	0.4	1.6	0.7	1.8	0.5
Static objects	1.3	1.3	1.4	1.0	1.3	0.8	1.2	0.7
Poisoning, ingestion/ inhalation	4.3	12.4	4.5	13.7	5.2	13.0	5.6	14.6
Fire/explosion with fire	0.7	0.4	0.7	0.4	0.7	0.4	0.7	0.1
Other burns	0.7	0.5	0.9	0.6	0.9	0.9	0.7	0.7
Excessive heat	0.8	0.4	1.3	1.6	1.8	4.0	1.6	4.7
Excessive cold	1.5	1.4	1.0	0.8	0.5	1.3	1.4	1.9
Fall or jump	10.4	12.2	10.6	12.2	10.4	11.7	10.2	12.1
Marching and drilling	0.3	0.8	0.3	0.8	0.3	1.0	0.4	0.3
Twisting/turning/slipping/ running NEC	1.9	2.1	2.1	2.7	1.9	1.5	2.1	1.8
Lifting/pushing/pulling	0.8	0.7	0.8	1.2	0.9	0.8	0.9	1.1
Fighting NEC 3	7.3	2.9	6.7	2.6	5.7	2.2	6.1	2.6
Unspecified/unknown agent	8.6	8.1	5.3	4.5	6.8	6.1	6.7	6.4
Other specified agent	10.3	8.6	11.4	11.4	11.6	10.9	10.7	10.3

[1]/Percent of total nonbattle injury dispositions for specified gender
[2]/Not used as instrumentality of war against the enemy
[3]/NEC "not elsewhere classified"

Table A-21

Gender Differentials for ADA Personnel Time Lost to Hospitalization, Worldwide, 1982-1985: Percent of Sick Days [1] by Causative Agent

Causative Agent	CY 82		CY 83		CY 84		CY 85	
	M	F	M	F	M	F	M	F
Air transport for spacecraft accidents	2.3	0.6	3.4	1.4	2.2	1.3	2.6	1.9
Motor vehicle accidents	29.5	18.2	29.3	19.2	25.1	19.3	24.7	16.9
Athletics/sports/ physical training	10.6	7.1	9.8	6.9	10.7	5.0	9.4	6.0
Complications, prophylactic inoculation	0.1	0.3	0.2	0.3	0.1	0.1	0.2	0.2
Complications, other medical procedures	7.8	26.9	8.0	21.8	9.6	20.5	9.2	19.2
Small arms weapons [2]	3.3	0.7	2.9	0.8	2.1	0.5	1.8	0.9
Other guns, explosives, etc. [2]	1.5	0.0	1.6	0.2	1.4	0.2	1.7	0.1
Cutting/piercing instruments/Objects	4.1	3.1	4.4	2.4	3.6	4.1	3.4	2.6
Falling/projected objects/missiles	0.9	0.3	1.0	0.4	0.9	0.2	1.4	0.2
Static objects	0.8	0.3	0.8	0.5	0.5	0.2	0.6	0.2
Poisoning, ingestion/ inhalation	1.2	4.8	1.3	4.2	1.6	3.2	1.7	4.6
Fire/explosion with fire	1.0	1.1	0.8	0.4	0.8	1.1	0.8	0.2
Other burns	0.5	0.5	0.8	0.5	0.6	0.7	0.4	0.9
Excessive heat	0.2	0.1	0.2	0.2	0.3	0.4	0.2	0.7
Excessive cold	0.5	0.9	0.3	0.2	0.2	0.5	0.6	0.4
Fall or jump	10.5	12.3	10.5	15.1	10.3	15.9	8.9	15.2
Marching and drilling	0.3	0.7	0.2	0.7	0.3	0.5	0.4	0.1
Twisting/turning/slipping/ running NEC [3]	1.7	2.8	1.9	2.2	1.7	1.2	1.6	2.0
Lifting/pushing/pulling	0.5	0.3	0.5	0.8	0.5	0.5	0.4	0.3
Fighting NEC [3]	5.0	1.4	4.1	1.4	3.4	1.0	3.1	0.9
Unspecified/unknown agent	12.2	10.8	11.9	13.4	17.6	17.7	20.9	19.6
Other specified agent	5.6	6.7	6.3	7.0	6.6	6.0	6.0	7.0

[1]/ Percent of total sick days (on hospital rolls) attributed to nonbattle injury for gender.
[2]/ Not used as instrumentality of war against the enemy
[3]/ NEC: "not elsewhere classified"

APPENDIX B

Ambulatory Health Care Utilization

for

All Active Duty Army Personnel at Six ACDB Sites,

Twelve Basic Trainee Companies at One ACDB Site,

and

Six Garrison-Level Units at One ACDB Site

Table B-1

Top 50 Ambulatory Diagnoses for All Active Duty Army Soldiers at Six Sites for 15 Months

FREQUENCY	CODE	DIAGNOSIS DESCRIPTION	PERCENT	CUM PERC
63441	V655	NO PROBLEM NOTED	8.90%	8.90%
27081	4602	URI ACUTE (COLD)	3.80%	12.69%
22736	7295	PAIN, EXTREMITY	3.19%	15.88%
14971	8450	SPRAIN/STRAIN, ANKLE	2.10%	17.98%
14797	848	SPRAIN/STRAIN, SITE NOS	2.07%	20.05%
13378	95971	INJURY/PAIN, KNEE, NOS	1.88%	21.93%
13041	V700	EXAM, MEDICAL	1.83%	23.76%
12703	000	NO DIAGNOSIS/REASON FOR VISIT RECORDED BY PROVIDER	1.78%	25.54%
12329	7245	PAIN, BACK, NOS	1.73%	27.27%
10331	V22	PREGNANCY, NORMAL	1.45%	28.72%
9516	V5841	AFTERCARE, KNEE SURGERY	1.33%	30.05%
8382	462	PHARYNGITIS, ACUTE	1.18%	31.23%
8361	0799	VIRAL SYNDROME NOS	1.17%	32.40%
7542	7242	PAIN, LUMBAR/SACRAL	1.06%	33.46%
7470	55890	GASTROENTERITIS	1.05%	34.50%
7139	72969	MUSCULOSKELETAL PROBLEM, OTHER	1.00%	35.50%
7053	36725	ASTIGMATISM, MYOPIC	0.99%	36.49%
6778	84892	SPRAIN/STRAIN, MUSCLES & TENDONS	0.95%	37.44%
6115	3671	MYOPIA	0.86%	38.30%
6050	829	FRACTURE, NOS (CLOSED)	0.85%	39.15%
6003	7298	PAIN, EXTREMITY (NOT JOINT)	0.84%	39.99%
5758	9249	CONTUSION, NOS	0.81%	40.80%
5164	7890	PAIN, ABDOMINAL	0.72%	41.52%
5055	477	RHINITIS, ALLERGIC	0.71%	42.23%
4994	72992	SOFT TISSUE DISORDERS	0.70%	42.93%
4651	7194	ARTHRALGIA	0.68%	43.61%
4678	7291	MYALGIA	0.66%	44.27%
4550	V7231	EXAM, WELL WOMAN	0.64%	44.90%
4410	098	GONORRHEA	0.62%	45.52%
4275	7840	HEADACHE	0.60%	46.12%
4237	87981	LACERATION, SIMPLE (<2 INCH)	0.59%	46.71%
4152	84891	SPRAIN/STRAIN, JOINT (LIGAMENTS)	0.58%	47.30%
3883	7821	RASH (EXANTHEMS), NOS	0.54%	47.84%
3818	V5371	NEEDS ORTHOTIC APPLIANCE	0.54%	48.38%
3723	461	SINUSITIS, ACUTE	0.52%	48.90%
3718	0781	WART, VIRAL	0.52%	49.42%
3675	70481	PSEUDOFOLLICULITIS BARBAE	0.52%	49.93%
3642	7231	PAIN, CERVICAL	0.51%	50.45%
3516	2780	OBESITY	0.49%	50.94%
3486	8479	SPRAIN/STRAIN, BACK	0.49%	51.43%
3456	0994	URETHRITIS, NONSPECIFIC	0.48%	51.91%
3313	7865	PAIN, CHEST	0.46%	52.38%
3255	4660	BRONCHITIS, ACUTE	0.46%	52.83%
3244	7030	INGROWN TOENAIL	0.45%	53.29%
3183	692	DERMATITIS, CONTACT, NOS	0.45%	53.73%
3161	7870	NAUSEA/VOMITING	0.44%	54.18%
3097	401	HYPERTENSION, ESSENTIAL	0.43%	54.61%
3042	55591	DIARRHEA	0.43%	55.04%
2953	0340	PHARYNGITIS W/STREPTOCOCCAL	0.41%	55.45%
2920	7862	COUGH	0.41%	55.86%

Table B-2

Top 50 Ambulatory Diagnoses for Female Active Duty Army Soldiers at Six Sites for 15 Months

FREQUENCY	CODE	DIAGNOSIS DESCRIPTION	PERCENT	CUM PERCENT
10978	V655	NO PROBLEM NOTED	6.77%	6.77%
9681	V22	PREGNANCY, NORMAL	5.97%	12.75%
6981	7295	PAIN, EXTREMITY	4.31%	17.06%
5653	4602	URI ACUTE (COLD)	3.49%	20.54%
4385	V7231	EXAM, WELL WOMAN	2.71%	23.25%
3105	8450	SPRAIN/STRAIN, ANKLE	1.92%	25.17%
3060	848	SPRAIN/STRAIN, SITE NOS	1.89%	27.05%
3015	000	NO DIAGNOSIS/REASON FOR VISIT RECORDED BY PROVIDER	1.86%	31.74%
2480	V2501	ORAL CONTRACEPTIVES	1.53%	28.58%
2093	3671	MYOPIA	1.29%	29.86%
2012	7245	PAIN, BACK, NOS	1.24%	32.98%
2000	36725	ASTIGMATISM, MYOPIC	1.23%	34.21%
1918	075.	VIRAL SYNDROME NOS	1.18%	35.39%
1909	V724	POSSIBLE PREGNANCY	1.18%	36.57%
1768	7298	PAIN, EXTREMITY (NOT JOINT)	1.09%	37.66%
1749	625	PAIN, PELVIC	1.08%	38.74%
1742	95971	INJURY/PAIN, KNEE, NOS	1.07%	39.82%
1584	55890	GASTROENTERITIS	0.98%	40.80%
1578	7890	PAIN, ABDOMINAL	0.97%	41.77%
1561	462	PHARYNGITIS, ACUTE	0.96%	42.73%
1450	V681	REFILL MEDICATION	0.89%	43.63%
1373	6235	DISCHARGE, VAGINAL NOS	0.85%	44.47%
1364	7242	PAIN, LUMBAR/SACRAL	0.84%	45.32%
1346	72989	MUSCULOSKELETAL PROBLEM, OTHER	0.83%	46.15%
1134	477	RHINITIS, ALLERGIC	0.70%	46.85%
1111	7840	HEADACHE	0.69%	47.53%
1110	5990	INFECTION, URINARY TRACT	0.68%	48.22%
1088	72671	BURSITIS/TENDINITIS, ACHILLES	0.67%	48.89%
1063	V23	PREGNANCY, HIGH RISK	0.66%	49.54%
970	6269	DISORDERS OF MENSTRUATION	0.60%	50.14%
959	72992	SOFT TISSUE DISORDERS	0.59%	50.73%
938	84892	SPRAIN/STRAIN, MUSCLES & TENDONS	0.58%	51.31%
936	V700	EXAM, MEDICAL	0.58%	51.89%
900	7870	NAUSEA/VOMITING	0.56%	52.45%
886	72886	OVERUSE SYNDROME (SOFT TISSUE), LOWER LEG	0.55%	52.99%
881	7291	MYALGIA	0.54%	53.54%
837	1121	MONILIASIS, VULVA & VAGINA	0.52%	54.05%
811	461	SINUSITIS, ACUTE	0.50%	54.55%
809	75461	PES PLANUS, CONGENITAL (PRONATORY COMPENSATION)	0.50%	55.05%
793	7194	ARTHRALGIA	0.49%	55.54%
772	9249	CONTUSION, NOS	0.48%	56.02%
736	700	CORNS, CALLOSITIES	0.46%	56.47%
726	7865	PAIN, CHEST	0.45%	56.92%
717	7862	COUGH	0.44%	57.36%
695	7821	RASH, EXANTHEMS, NOS	0.43%	57.79%
687	2780	OBESITY	0.42%	58.21%
683	61612	VAGINITIS, NOS	0.42%	58.64%
664	71496	PATELLA SYNDROME	0.41%	59.05%
658	V242	POSTPARTUM, ROUTINE FOLLOWUP	.41%	59.46%
656	7931	FRACTURE, PATHOLOGICAL	.41%	59.86%

Table B-3

Top 50 Ambulatory Diagnoses for Male Active Duty Army Soldiers at Six Sites for 15 Months

FREQUENCY	CODE	DIAGNOSIS DESCRIPTION	PERCENT	CUM PERCENT
52460	V655	NO PROBLEM NOTED	9.52%	9.52%
21426	4602	URI ACUTE (COLD)	3.89%	13.41%
15755	7295	PAIN, EXTREMITY	2.86%	16.27%
12103	V700	EXAM, MEDICAL	2.20%	18.46%
11886	8450	SPRAIN/STRAIN, ANKLE	2.15%	20.62%
11737	848	SPRAIN/STRAIN, SITE NOS	2.13%	22.75%
11636	95971	INJURY/PAIN, KNEE, NOS	2.11%	24.86%
10676	000	NO DIAGNOSIS/REASON FOR VISIT RECORDED BY PROVIDER	1.94%	26.80%
10317	7245	PAIN, BACK, NOS	1.87%	28.67%
8895	V5841	AFTERCARE, KNEE SURGERY	1.61%	30.28%
6821	462	PHARYNGITIS, ACUTE	1.24%	31.52%
6443	0799	VIRAL SYNDROME NOS	1.17%	32.69%
6177	7242	PAIN, LUMBAR/SACRAL	1.12%	33.81%
5886	55890	GASTROENTERITIS	1.07%	34.88%
5840	84892	SPRAIN/STRAIN, MUSCLES & TENDONS	1.06%	35.94%
5793	72969	MUSCULOSKELETAL PROBLEM, OTHER	1.05%	36.99%
5494	829	FRACTURE, NOS (CLOSED)	1.00%	37.99%
5063	36725	ASTIGMATISM, MYOPIC	0.92%	38.90%
4936	9249	CONTUSION, NOS	0.90%	39.81%
4235	7298	PAIN, EXTREMITY (NOT JOINT)	0.77%	40.58%
4058	7194	ARTHRALGIA	0.74%	41.31%
4035	72992	SOFT TISSUE DISORDERS	0.73%	42.05%
4022	3671	MYOPIA	0.73%	42.78%
3981	87981	LACERATION, SIMPLE (<2 INCH)	0.72%	43.50%
3921	477	RHINITIS, ALLERGIC	0.71%	44.21%
3826	098	GONORRHEA	0.69%	44.91%
3797	7291	MYALGIA	0.69%	45.59%
3745	84891	SPRAIN/STRAIN, JOINT (LIGAMENTS)	0.68%	46.27%
3632	70481	PSEUDOFOLLICULITIS BARBAE	0.66%	46.93%
3586	7890	PAIN, ABDOMINAL	0.65%	47.58%
3434	0994	URETHRITIS, NONSPECIFIC	0.62%	48.21%
3417	0781	WART, VIRAL	0.62%	48.83%
3359	V5371	NEEDS ORTHOTIC APPLIANCE	0.61%	49.44%
3186	7821	RASH (EXANTHEMS), NOS	0.58%	50.01%
3163	7840	HEADACHE	0.57%	50.59%
3094	8479	SPRAIN/STRAIN, BACK	0.56%	51.15%
2999	7231	PAIN, CERVICAL	0.54%	51.69%
2912	461	SINUSITIS, ACUTE	0.53%	52.22%
2822	401	HYPERTENSION, ESSENTIAL	0.51%	52.74%
2819	2780	OBESITY	0.51%	53.25%
2761	7030	INGROWN TOENAIL	0.50%	53.75%
2699	692	DERMATITIS, CONTACT, NOS	0.49%	54.24%
2647	52298	SOCIAL MAL PROBLEMS, OTHER, I	0.48%	54.72%
2619	4660	BRONCHITIS, ACUTE	0.48%	55.20%
2515	V6284	BLOOD PRESSURE CHECK	0.47%	55.67%
2476	5939	DIARRHEA	0.47%	56.13%
2397	7850	PAIN, CHEST	0.47%	56.61%
2344	7840	EMOTIONAL & PSYCHOLOGICAL	0.47%	57.08%
2342	7850	ACNE	0.47%	57.55%
2281	7840	NAUSEA & VOMITING	0.47%	58.02%

Table B-4

Rank Ordered Summary of the Top 50 Ambulatory Diagnoses By Gender for All Active Duty Army Soldiers at Six Sites for 15 Months

RANK	CODE	DIAGNOSIS DESCRIPTION	FEMALE DIAGNOSIS RANK	MALE DIAGNOSIS RANK
1	V655	NO PROBLEM NOTED	1	1
2	4602	URI ACUTE (COLD)	4	2
3	7295	PAIN, EXTREMITY	3	3
4	8450	SPRAIN/STRAIN, ANKLE	6	5
5	848	SPRAIN/STRAIN, SITE NOS	7	6
6	95971	INJURY/PAIN, KNEE, NOS	17	7
7	V700	EXAM, MEDICAL	33	4
8	000	NO DIAGNOSIS/REASON FOR VISIT RECORDED BY PROVIDER	8	8
9	7245	PAIN, BACK, NOS	11	9
10	V22	PREGNANCY, NORMAL	2	
11	V5841	AFTERCARE, KNEE SURGERY		10
12	462	PHARYNGITIS, ACUTE	20	11
13	0799	VIRAL SYNDROME NOS	13	12
14	7242	PAIN, LUMBAR/SACRAL	23	13
15	55890	GASTROENTERITIS	18	14
16	72989	MUSCULOSKELETAL PROBLEM, OTHER	24	16
17	36725	ASTIGMATISM, MYOPIC	12	18
18	84892	SPRAIN/STRAIN, MUSCLES & TENDONS	32	15
19	3671	MYOPIA	10	23
20	829	FRACTURE, NOS (CLOSED)		17
21	7298	PAIN, EXTREMITY (NOT JOINT)	15	20
22	9249	CONTUSION, NOS	41	19
23	7890	PAIN, ABDOMINAL	19	30
24	477	RHINITIS, ALLERGIC	25	25
25	72992	SOFT TISSUE DISORDERS	31	22
26	7194	ARTHRALGIA	40	21
27	7291	MYALGIA	36	27
28	V7231	EXAM, WELL WOMAN	5	
29	098	GONORRHEA		26
30	7840	HEADACHE	25	35
31	87981	LACERATION, SIMPLE (<2 INCH)		24
32	84891	SPRAIN/STRAIN, JOINT (LIGAMENTS)		28
33	7821	RASH (EXANTHEMS), NOS	45	34
34	V5371	NEEDS ORTHOTIC APPLIANCE		33
35	461	SINUSITIS, ACUTE	38	38
36	0781	WART, VIRAL		32
37	70481	PSEUDOFOLLICULITIS BARBAE		29
38	7231	PAIN, CERVICAL		37
39	2780	OBESITY	46	40
40	8479	SPRAIN/STRAIN, BACK		36
41	0994	URETHRITIS, NONSPECIFIC		31
42	7865	PAIN, CHEST	43	47
43	4660	BRONCHITIS, ACUTE		44
44	7030	INGROWN TOENAIL		41
45	692	DERMATITIS, CONTACT, NOS		42
46	7870	NAUSEA/VOMITING	34	50
47	401	HYPERTENSION, ESSENTIAL		39
48	55891	DIARRHEA		46
49	0340	PHARYNGITIS W/STREPTOCOCCAL		48
50	7862	COUGH	44	

Table B-5

Weekly Census, Mean Cycle Strength, and Attrition Rates for Basic Trainee Sample

UNIT	WEEK								MEAN	ATTRITION	
	1	2	3	4	5	6	7	8		(%)	(n)
1*	227	223	223	223	220	217	209	205	218	10	(22)
2	261	258	258	258	257	256	250	246	256	2	(5)
3*	231	226	227	227	222	219	214	204	221	12	(27)
4	251	252	252	250	249	246	241	235	247	6	(16)
5*	223	224	221	218	216	214	213	196	216	12	(27)
6	238	240	240	234	232	231	229	219	233	8	(19)
7*	216	215	214	214	191	196	194	191	204	12	(25)
8	199	199	198	197	195	194	192	191	196	4	(8)
9*	115	115	115	115	115	115	113	113	115	2	(2)
10	182	179	182	178	178	176	175	179	177	2	(3)
11*	201	201	201	199	199	196	193	189	197	6	(12)
12	179	179	178	176	173	171	178	167	174	7	(12)

* Female Unit

Table B-6

Encounter Rates Per Individual for Each of 12 Basic Trainee Cycles at One Site

Group	Avg Unit Strength	# of Encounters Per Unit	Rate per Individual
5*	216	211	0.98
12	174	151	0.87
3*	221	184	0.83
1*	218	168	0.77
7*	204	146	0.72
10	177	96	0.54
11*	197	98	0.50
2	256	110	0.43
8	196	62	0.32
9*	115	32	0.28
4	247	70	0.28
6	233	52	0.22

***Female unit**

females (n=1171)

males (n=1283)

Table B-7

Top 50 Ambulatory Diagnoses for 12 Basic Trainee Cycles at One Site for One Year

FREQUENCY	CODE	DIAGNOSIS DESCRIPTION	PERCENT	CUM PERCENT
239	7295	PAIN, EXTREMITY	17.32%	17.32%
88	8450	SPRAIN/STRAIN, ANKLE	6.38%	23.70%
54	75461	PES PLANUS, CONGENITAL (PRONATORY COMPENSATION)	3.91%	27.61%
53	848	SPRAIN/STRAIN, SITE NOS	3.84%	31.45%
41	7298	PAIN, EXTREMITY (NOT JOINT)	2.97%	34.42%
38	7245	PAIN, BACK, NOS	2.75%	37.17%
34	7030	INGROWN TOENAIL	2.46%	39.64%
30	4602	URI ACUTE (COLD)	2.17%	41.81%
26	73316	STRESS FRACTURE, PUBIC RAMI	1.88%	43.70%
21	3089	ACUTE REACTION TO STRESS, UNSPEC	1.52%	45.22%
21	V655	NO PROBLEM NOTED	1.52%	46.74%
21	73313	FRACTURE, FOOT, STRESS	1.52%	48.26%
20	700	CORNS, CALLOSITIES	1.45%	49.71%
20	79983	WEAKNESS	1.45%	51.16%
19	72671	BURSITIS/TENDINITIS, ACHILLES	1.38%	52.54%
19	9172	FRICTION BLISTER, FEET	1.38%	53.91%
17	71887	INSTABILITY, ANKLE	1.23%	55.14%
15	82525	FRACTURE, METATARSAL (CLOSED)	1.09%	56.23%
14	098	GONORRHEA	1.01%	57.25%
14	7195	JOINT STIFFNESS	1.01%	58.26%
14	95971	INJURY/PAIN, KNEE, NOS	1.01%	59.28%
13	V724	POSSIBLE PREGNANCY	0.94%	60.22%
12	7331	FRACTURE, PATHOLOGICAL	0.87%	61.09%
12	73314	FRACTURE, LEG, STRESS	0.87%	61.96%
12	9249	CONTUSION, NOS	0.87%	62.83%
12	70481	PSEUDOFOLLICULITIS BARBAE	0.87%	63.70%
11	71996	PATELLA SYNDROME	0.80%	64.49%
11	72886	OVERUSE SYNDROME (SOFT TISSUE), LOWER LEG	0.80%	65.29%
11	625	PAIN, PELVIC	0.80%	66.09%
10	72871	PLANTAR FASCITIS	0.72%	66.81%
10	72992	SOFT TISSUE DISORDERS	0.72%	67.54%
10	7821	RASH (EXANTHEMS), NOS	0.72%	68.26%
10	72989	MUSCULOSKELETAL PROBLEM, OTHER	0.72%	68.99%
9	07981	CHLAMYDIA	0.65%	69.64%
9	6269	DISORDERS OF MENSTRUATION	0.65%	70.29%
9	6926	DERMATITIS, CONTACT, PLANTS, EXCEPT FOOD	0.65%	70.94%
8	7955	TUBERCULIN REACTOR, NONSPEC	0.58%	71.52%
8	8260	FRACTURE, TOE(S) (CLOSED)	0.58%	72.10%
7	72984	LOWER EXTREMITY DISORDER	0.51%	72.61%
7	73315	STRESS FRACTURE, BOOT TOP	0.51%	73.12%
7	72672	BURSITIS/TENDINITIS, NOS	0.51%	73.62%
7	0000	NO DIAGNOSIS GIVEN BY PROVIDER	0.51%	74.13%
7	7242	PAIN, LUMBAR/SACRAL	0.51%	74.64%
7	7865	PAIN, CHEST	0.51%	75.14%
6	71946	PAIN, KNEE	0.43%	75.58%
6	5259	TEETH & SUPPORT STRUCTURE DISEASE	0.43%	76.01%
6	604	ORCHITIS & EPIDIDYMITIS	0.43%	76.45%
6	V7201	REQUEST FOR GLASSES	0.43%	76.88%
6	6309	BOIL/CARBUNCLE	0.43%	77.32%
6	7291	MYALGIA	0.43%	77.75%

Table B-8

Top 50 Ambulatory Diagnoses for Female Basic Trainee Sample At One Site for One Year

FREQUENCY	CODE	DIAGNOSIS DESCRIPTION	PERCENT	CUM PERCENT
145	7295	PAIN, EXTREMITY	17.28%	17.28%
44	8450	SPRAIN/STRAIN, ANKLE	5.24%	22.53%
38	848	SPRAIN/STRAIN, SITE NOS	4.53%	27.06%
36	75461	PES PLANUS, CONGENITAL (PRONATORY COMPENSATION)	4.29%	31.35%
28	7245	PAIN, BACK, NOS	3.34%	34.68%
21	7298	PAIN, EXTREMITY (NOT JOINT)	2.50%	37.19%
18	73313	FRACTURE, FOOT, STRESS	2.15%	39.33%
17	4602	URI ACUTE (COLD)	2.03%	41.36%
16	7030	INGROWN TOENAIL	1.91%	43.27%
16	79983	WEAKNESS	1.91%	45.17%
13	V724	POSSIBLE PREGNANCY	1.55%	46.72%
13	700	CORNS, CALLOSITIES	1.55%	48.27%
13	V655	NO PROBLEM NOTED	1.55%	49.82%
12	3089	ACUTE REACTION TO STRESS, UNSPEC	1.43%	51.25%
11	625	PAIN, PELVIC	1.31%	52.56%
11	72671	BURSITIS/TENDINITIS, ACHILLES	1.31%	53.87%
11	9249	CONTUSION, NOS	1.31%	55.18%
10	73316	STRESS FRACTURE, PUBIC RAMI	1.19%	56.38%
10	098	GONORRHEA	1.19%	57.57%
10	72992	SOFT TISSUE DISORDERS	1.19%	58.76%
9	72989	MUSCULOSKELETAL PROBLEM, OTHER	1.07%	59.83%
9	95971	INJURY/PAIN, KNEE, NOS	1.07%	60.91%
9	72886	OVERUSE SYNDROME (SOFT TISSUE), LOWER LEG	1.07%	61.98%
9	71887	INSTABILITY, ANKLE	1.07%	63.05%
8	72871	PLANTAR FASCITIS	0.95%	64.00%
8	82525	FRACTURE, METATARSAL (CLOSED)	0.95%	64.96%
7	7331	FRACTURE, PATHOLOGICAL	0.83%	65.79%
7	9172	FRICTION BLISTER, FEET	0.83%	66.63%
7	73314	FRACTURE, LEG, STRESS	0.83%	67.46%
6	72984	LOWER EXTREMITY DISORDER	0.72%	68.18%
6	36725	ASTIGMATISM, MYOPIC	0.72%	68.89%
6	72672	BURSITIS/TENDINITIS, NOS	0.72%	69.61%
6	71946	PAIN, KNEE	0.72%	70.32%
6	V7201	REQUEST FOR GLASSES	0.72%	71.04%
6	3891	HEARING LOSS, SENSORINEURAL	0.72%	71.75%
6	7242	PAIN, LUMBAR/SACRAL	0.72%	72.47%
6	6269	DISORDERS OF MENSTRUATION	0.72%	73.18%
5	0000	NO DIAGNOSIS GIVEN BY PROVIDER	0.60%	73.78%
5	7821	RASH (EXANTHEMS), NOS	0.60%	74.37%
5	8260	FRACTURE, TOE(S) (CLOSED)	0.60%	74.97%
5	5259	TEETH & SUPPORT STRUCTURE DISEASE	0.60%	75.57%
5	6811	CELLULITIS, TOE	0.60%	76.16%
4	7291	MYALGIA	0.48%	76.64%
4	72710	BUNION, 1ST METATARSAL	0.48%	77.12%
4	6235	DISCHARGE, VAGINAL NOS	0.48%	77.59%
4	3556	NEUROMA, MORTON'S (PLANTAR NERVE)	0.48%	78.07%
4	71796	PATELLA SYNDROME	0.48%	78.55%
4	7244	PAIN, BACK, W/RADIATING SYMPTOMS	0.48%	79.02%
4	7195	JOINT STIFFNESS	0.48%	79.50%
4	7865	PAIN, CHEST	0.48%	79.98%

Table B-9

Top 50 Ambulatory Diagnoses for Male Basic Trainee Sample at One Site for One Year

FREQUENCY	CODE	DIAGNOSIS DESCRIPTION	PERCENT	CUM PERCENT
94	7295	PAIN, EXTREMITY	17.36%	17.36%
44	8450	SPRAIN/STRAIN, ANKLE	8.13%	25.51%
20	7296	PAIN, EXTREMITY (NOT JOINT)	3.70%	29.21%
18	7030	INGROWN TOENAIL	3.33%	32.53%
18	75461	PES PLANUS, CONGENITAL (PRONATORY COMPENSATION)	3.33%	35.86%
16	73316	STRESS FRACTURE, PUBIC RAMI	2.96%	38.82%
15	848	SPRAIN/STRAIN, SITE NOS	2.77%	41.59%
13	4602	URI ACUTE (COLD)	2.40%	43.99%
12	70481	PSEUDOFOLLICULITIS BARBAE	2.22%	46.21%
12	9172	FRICTION BLISTER, FEET	2.22%	48.43%
10	7195	JOINT STIFFNESS	1.85%	50.28%
10	7245	PAIN, BACK, NOS	1.85%	52.13%
9	3089	ACUTE REACTION TO STRESS, UNSPEC	1.66%	64.51%
8	V655	NO PROBLEM NOTED	1.48%	55.60%
8	71887	INSTABILITY, ANKLE	1.48%	55.08%
8	72671	BURSITIS/TENDINITIS, ACHILLES	1.48%	56.56%
7	6926	DERMATITIS, CONTACT, PLANTS, EXCEPT FOOD	1.29%	57.86%
7	700	CORNS, CALLOSITIES	1.29%	59.15%
7	71996	PATELLA SYNDROME	1.29%	60.44%
7	82525	FRACTURE, METATARSAL (CLOSED)	1.29%	61.74%
6	07981	CHLAMYDIA	1.11%	62.85%
6	604	ORCHITIS & EPIDIDYMITIS	1.11%	65.62%
6	6869	BOIL/CARBUNCLE	1.11%	66.73%
6	9173	BLISTER, W/INFECTION	1.11%	67.84%
5	07813	WARTS, PLANTAR	0.92%	68.76%
5	7241	PAIN, THORACIC	0.92%	69.69%
5	7331	FRACTURE, PATHOLOGICAL	0.92%	70.61%
5	73314	FRACTURE, LEG, STRESS	0.92%	71.53%
5	7821	RASH (EXANTHEMS), NOS	0.92%	72.46%
5	7955	TUBERCULIN REACTOR, NONSPEC	0.92%	73.38%
5	95971	INJURY/PAIN, KNEE, NOS	0.92%	74.31%
4	098	GONORRHEA	0.74%	75.05%
4	73315	STRESS FRACTURE, BOOT TOP	0.74%	75.79%
4	79983	WEAKNESS	0.74%	76.52%
4	84491	STRAIN, LOWER LEG	0.74%	77.26%
4	8479	SPRAIN/STRAIN, BACK	0.74%	78.00%
3	3820	OTITIS MEDIA, SUPPURATIVE, ACUTE	0.55%	78.56%
3	462	PHARYNGITIS, ACUTE	0.55%	79.11%
3	6269	DISORDERS OF MENSTRUATION	0.55%	79.67%
3	68291	ABSCESS	0.55%	80.22%
3	73313	FRACTURE, FOOT, STRESS	0.55%	80.78%
3	7865	PAIN, CHEST	0.55%	81.33%
3	78831	ENURESIS	0.55%	81.89%
3	8260	FRACTURE, TOE(S) (CLOSED)	0.55%	82.44%
2	V2509	CONTRACEPTIVE GUIDANCE	0.37%	82.81%
2	0000	NO DIAGNOSIS GIVEN BY PROVIDER	0.37%	83.18%
2	36723	ASTIGMATISM, HYPEROPIC	0.37%	83.55%
2	3703	KERATOCONJUNCTIVITIS	0.37%	83.92%
2	55391	DIARRHEA	0.37%	84.29%
2	683	LYMPHADENITIS, ACUTE	0.37%	84.66%

Table B-10

Rank Ordered Summary of the Top 50 Ambulatory Diagnoses By Gender for the Basic Trainee Sample for One Year

RANK	FREQUENCY	CODE	DIAGNOSIS DESCRIPTION	FEMALE DIAGNOSIS RANK	MALE DIAGNOSIS RANK
1	239	7295	PAIN, EXTREMITY	1	1
2	88	8450	SPRAIN/STRAIN, ANKLE	2	2
3	54	75461	PES PLANUS, CONGENITAL (PRONATORY COMPENSATION)	4	5
4	53	848	SPRAIN/STRAIN, SITE NOS	3	7
5	41	7298	PAIN, EXTREMITY (NOT JOINT)	6	3
6	38	7245	PAIN, BACK, NOS	5	12
7	34	7030	INGROWN TOENAIL	8	4
8	30	4602	URI ACUTE (COLD)	7	8
9	26	73316	STRESS FRACTURE, PUBIC RAMI	19	6
10	21	V655	NO PROBLEM NOTED	11	13
11	20	700	CORNS, CALLOSITIES	13	17
12	20	79783	WEAKNESS	10	34
13	19	72671	BURSITIS/TENDINITIS, ACHILLES	15	15
14	19	73313	FRACTURE, FOOT, STRESS	9	42
15	19	9172	FRICTION BLISTER, FEET	29	10
16	17	71887	INSTABILITY, ANKLE	20	14
17	15	82525	FRACTURE, METATARSAL (CLOSED)	26	19
18	14	098	GONORRHEA	17	32
19	14	3089	ACUTE REACTION TO STRESS, UNSPEC	24	21
20	14	7195	JOINT STIFFNESS	46	11
21	14	95971	INJURY/PAIN, KNEE, NOS	23	31
22	13	V724	POSSIBLE PREGNANCY	12	
23	12	70481	PSEUDOFOLLICULITIS BARBAE		9
24	12	7331	FRACTURE, PATHOLOGICAL	27	27
25	12	73314	FRACTURE, LEG, STRESS	28	28
26	12	9249	CONTUSION, NOS	16	
27	11	625	PAIN, PELVIC	14	
28	11	71996	PATELLA SYNDROME	47	16
29	11	72886	OVERUSE SYNDROME (SOFT TISSUE), LOWER LEG	21	
30	10	72871	PLANTAR FASCITIS	25	
31	10	72989	MUSCULOSKELETAL PROBLEM, OTHER	22	
32	10	72992	SOFT TISSUE DISORDERS	18	
33	10	7821	RASH (EXANTHEMS), NOS	41	29
34	9	07981	CHLAMYDIA		20
35	9	6269	DISORDERS OF MENSTRUATION	33	
36	9	6926	DERMATITIS, CONTACT, PLANTS, EXCEPT FOOD		16
37	8	7955	TUBERCULIN REACTOR, NONSPEC		30
38	8	8260	FRACTURE, TOE(S) (CLOSED)	42	44
39	7	0000	NOT CODED BY PROVIDER	38	46
40	7	7242	PAIN, LUMBAR/SACRAL	35	
41	7	72672		36	
42	7	72984	LOWER EXTREMITY DISORDER	37	
43	7	73315	STRESS FRACTURE, BOOT TOP		33
44	7	7865	PAIN, CHEST		42
45	6	V7201	REQUEST FOR GLASSES	30	
46	6	36725	ASTIGMATISM, MYOPIC	31	
47	6	3891	HEARING LOSS, SENSORINEURAL	32	
48	6	5259	TEETH & SUPPORT STRUCTURE DISEASE	39	
49	6	604	ORCHITIS & EPIDIDYMITIS		22
50	6	6809	BOIL/CARBUNCLE		33

Table B-11

Top 50 Ambulatory Diagnoses for Garrison Sample at One Site for One Year

FREQUENCY	CODE	DIAGNOSIS DESCRIPTION	PERCENT	CUM PERCENT
230	V655	NO PROBLEM NOTED	7.84%	7.84%
138	4602	URI ACUTE (COLD)	4.70%	12.54%
128	7245	PAIN, BACK, NOS	4.36%	16.91%
103	8450	SPRAIN/STRAIN, ANKLE	3.51%	20.42%
88	7295	PAIN, EXTREMITY	3.00%	23.42%
81	848	SPRAIN/STRAIN, SITE NOS	2.76%	26.18%
77	462	PHARYNGITIS, ACUTE	2.62%	28.80%
66	55890	GASTROENTERITIS	2.25%	31.05%
62	7291	MYALGIA	2.11%	33.16%
58	311	DEPRESSION NOS	1.96%	35.14%
52	70481	PSEUDOFOLLICULITIS BARBAE	1.77%	36.91%
48	7296	PAIN, EXTREMITY (NOT JOINT)	1.64%	38.55%
45	84892	SPRAIN/STRAIN, MUSCLES & TENDONS	1.53%	40.08%
43	84891	SPRAIN/STRAIN, JOINT (LIGAMENTS)	1.47%	41.55%
41	7890	PAIN, ABDOMINAL	1.40%	42.94%
40	V700	EXAM, MEDICAL	1.36%	44.31%
39	7244	PAIN, BACK, W/RADIATING SYMPTOMS	1.33%	45.64%
38	7840	HEADACHE	1.30%	46.93%
36	7194	ARTHRALGIA	1.23%	48.16%
35	0799	VIRAL SYNDROME NOS	1.19%	49.35%
34	8479	SPRAIN/STRAIN, BACK	1.16%	50.51%
33	7821	RASH (EXANTHEMS), NOS	1.12%	51.64%
31	461	SINUSITIS, ACUTE	1.06%	52.69%
27	7870	NAUSEA/VOMITING	0.92%	53.61%
24	717	DERANGEMENT, INTERNAL KNEE	0.82%	54.43%
24	7231	PAIN, CERVICAL	0.82%	55.25%
24	9249	CONTUSION, NOS	0.82%	56.07%
23	6926	DERMATITIS, CONTACT, PLANTS, EXCEPT FOOD	0.78%	56.85%
22	1104	DERMATOPHYTOSIS (TINEA) PEDIS	0.75%	57.60%
22	692	DERMATITIS, CONTACT, NOS	0.75%	58.35%
21	V22	PREGNANCY, NORMAL	0.72%	59.07%
21	V724	POSSIBLE PREGNANCY	0.72%	59.78%
21	55891	DIARRHEA	0.72%	60.50%
21	7865	PAIN, CHEST	0.72%	61.21%
20	7030	INGROWN TOENAIL	0.68%	61.90%
19	919	INJURY, SUPERFICIAL (INCL ABRASION, BLISTER)	0.65%	62.54%
17	463	TONSILLITIS, ACUTE	0.58%	63.12%
17	5990	INFECTION, URINARY TRACT	0.58%	63.70%
17	87981	LACERATION, SIMPLE (<2 INCH)	0.58%	64.28%
16	72989	MUSCULOSKELETAL PROBLEM, OTHER	0.55%	64.83%
15	4556	HEMORRHOIDS W/O COMPLICATIONS	0.51%	65.34%
15	68291	ABSCESS	0.51%	65.85%
15	949	BURN, NOS	0.51%	66.36%
15	95971	INJURY/PAIN, KNEE, NOS	0.51%	66.87%
14	0340	PHARYNGITIS W/STREPTOCOCCAL	0.48%	67.35%
14	4660	BRONCHITIS, ACUTE	0.48%	67.83%
14	7842	COUGH	0.48%	68.30%
13	V7109	NO DIAGNOSIS ON AXIS I-II	0.44%	68.75%
13	94971	BURN, THERMAL, <5% BODY SURFACE	0.44%	69.19%
13	99954	INSECT BITE/STING	0.44%	69.63%

Table B-12

Top 50 Ambulatory Diagnoses for Female Garrison Sample at One Site for One Year

FREQUENCY	CODE	DIAGNOSIS DESCRIPTION	PERCENT	CUM PERCENT
44	V65	NO PROBLEM NOTED	6.93%	6.93%
26	4602	URI ACUTE (COLD)	4.09%	11.02%
26	5589	GASTROENTERITIS	4.09%	15.12%
25	8450	SPRAIN/STRAIN, ANKLE	3.94%	19.06%
22	7291	MYALGIA	3.46%	22.52%
20	7295	PAIN, EXTREMITY	3.15%	25.67%
20	7890	PAIN, ABDOMINAL	3.15%	28.82%
19	V724	POSSIBLE PREGNANCY	2.99%	31.81%
16	848	SPRAIN/STRAIN, SITE NOS	2.52%	34.33%
15	V22	PREGNANCY, NORMAL	2.36%	36.69%
15	462	PHARYNGITIS, ACUTE	2.36%	39.06%
15	7245	PAIN, BACK, NOS	2.36%	41.42%
12	7840	HEADACHE	1.89%	43.31%
12	84892	SPRAIN/STRAIN, MUSCLES & TENDONS	1.89%	45.20%
10	461	SINUSITIS, ACUTE	1.57%	46.77%
10	7870	NAUSEA/VOMITING	1.57%	48.35%
10	84891	SPRAIN/STRAIN, JOINT (LIGAMENTS)	1.57%	49.92%
9	5990	INFECTION, URINARY TRACT	1.42%	51.34%
9	7244	PAIN, BACK, W/RADIATING SYMPTOMS	1.42%	52.76%
8	7298	PAIN, EXTREMITY (NOT JOINT)	1.26%	54.02%
8	72989	MUSCULOSKELETAL PROBLEM, OTHER	1.26%	55.28%
7	625	PAIN, PELVIC	1.10%	56.38%
7	7865	PAIN, CHEST	1.10%	57.46%
6	6269	DISORDERS OF MENSTRUATION	0.94%	58.43%
6	6469	PREGNANCY, COMPLICATION, NOS	0.94%	59.37%
6	6926	DERMATITIS, CONTACT, PLANTS, EXCEPT FOOD	0.94%	60.31%
6	8479	SPRAIN/STRAIN, BACK	0.94%	61.26%
6	9249	CONTUSION, NOS	0.94%	62.20%
5	V700	EXAM, MEDICAL	0.79%	62.99%
5	37230	CONJUNCTIVITIS	0.79%	63.78%
5	55891	DIARRHEA	0.79%	64.57%
5	6238	BLEEDING, VAGINAL	0.79%	65.35%
5	68291	ABSCESS	0.79%	66.14%
5	717	DERANGEMENT, INTERNAL KNEE	0.79%	66.93%
5	7821	RASH (EXANTHEMS), NOS	0.79%	67.72%
5	7862	COUGH	0.79%	68.50%
5	95971	INJURY/PAIN, KNEE, NOS	0.79%	69.29%
4	1104	DERMATOPHYTOSIS (TINEA) PEDIS	0.63%	69.92%
4	692	DERMATITIS, CONTACT, NOS	0.63%	70.55%
4	7231	PAIN, CERVICAL	0.63%	71.18%
4	796	CLINICAL FINDINGS, ABNORMAL, NON-SPEC	0.63%	71.81%
4	8363	DISLOCATION, PATELLA (CLOSED)	0.63%	72.44%
3	V7109	NO DX/COND ON AXIS I/II	0.47%	72.91%
3	V7231	EXAM, WELL WOMAN	0.47%	73.39%
3	0799	VIRAL SYNDROME NOS	0.47%	73.86%
3	311	DEPRESSION NOS	0.47%	74.33%
3	3820	OTITIS MEDIA, SUPPURATIVE, ACUTE	0.47%	74.80%
3	4720	PHINITIS	0.47%	75.28%
3	7030	INGROWN TOENAIL	0.47%	75.75%
3	7194	ARTHRALGIA	0.47%	76.22%

Table B-13

Top 50 Ambulatory Diagnoses for Male Garrison Sample at One Site for One Year

FREQUENCY	CODE	DIAGNOSIS DESCRIPTION	PERCENT	CUM PERCENT
186	V655	NO PROBLEM NOTED	8.09%	8.09%
113	7245	PAIN, BACK, NOS	4.92%	13.01%
112	4602	URI ACUTE (COLD)	4.87%	17.88%
78	8450	SPRAIN,STRAIN, ANKLE	3.39%	21.27%
69	7295	PAIN, EXTREMITY	2.96%	24.23%
65	848	SPRAIN/STRAIN, SITE NOS	2.83%	27.06%
62	462	PHARYNGITIS, ACUTE	2.70%	29.75%
55	311	DEPRESSION NOS	2.39%	32.14%
52	70481	PSEUDOFOLLICULITIS BARBAE	2.26%	34.41%
40	55890	GASTROENTERITIS	1.74%	36.15%
40	7291	MYALGIA	1.74%	37.89%
40	7298	PAIN, EXTREMITY (NOT JOINT)	1.74%	39.63%
35	V700	EXAM, MEDICAL	1.52%	41.15%
33	7194	ARTHRALGIA	1.44%	42.58%
33	84891	SPRAIN/STRAIN, JOINT (LIGAMENTS)	1.44%	44.02%
33	84892	SPRAIN/STRAIN, MUSCLES & TENDONS	1.44%	45.45%
32	0799	VIRAL SYNDROME NOS	1.39%	46.85%
30	7244	PAIN, BACK, W/RADIATING SYMPTOMS	1.30%	48.15%
28	7821	RASH (EXANTHEMS), NOS	1.22%	49.37%
28	8479	SPRAIN/STRAIN, BACK	1.22%	50.59%
26	7840	HEADACHE	1.13%	51.72%
21	461	SINUSITIS, ACUTE	0.91%	52.63%
21	7890	PAIN, ABDOMINAL	0.91%	53.55%
20	7231	PAIN, CERVICAL	0.87%	54.41%
19	717	DERANGEMENT, INTERNAL KNEE	0.83%	55.24%
18	1104	DERMATOPHYTOSIS (TINEA) PEDIS	0.78%	56.02%
18	692	DERMATITIS, CONTACT, NOS	0.78%	56.81%
18	919	INJURY, SUPERFICIAL (INCL ABRASION, BLISTER)	0.78%	57.59%
18	9249	CONTUSION, NOS	0.78%	58.37%
17	6926	DERMATITIS, CONTACT, PLANTS, EXCEPT FOOD	0.74%	59.11%
17	7030	INGROWN TOENAIL	0.74%	59.85%
17	7870	NAUSEA/VOMITING	0.74%	60.59%
16	55891	DIARRHEA	0.70%	61.29%
16	87401	LACERATION, SIMPLE (<2 INCH)	0.70%	61.98%
15	4556	HEMORRHOIDS W/O COMPLICATIONS	0.65%	62.64%
15	463	TONSILLITIS, ACUTE	0.65%	63.29%
15	949	BURN, NOS	0.65%	63.94%
14	7865	PAIN, CHEST	0.61%	64.55%
12	0540	PHARYNGITIS W/STREPTOCOCCAL	0.52%	65.07%
12	4660	BRONCHITIS, ACUTE	0.52%	65.59%
11	436	CEREBROVASCULAR ACCIDENT (CVA)	0.48%	66.07%
11	94971	BURN, THERMAL, .5% BODY SURFACE	0.48%	66.55%
11	98954	INSECT BITE/STING	0.48%	67.03%
10	V7109	NO DX/COND ON AXIS I/II	0.43%	67.46%
10	493	ASTHMA	0.43%	67.90%
10	68291	ABSCESS	0.43%	68.33%
10	70522	CYST, SEBACEOUS	0.43%	68.77%
10	7270	SYNOVITIS TENOSYNOVITIS	0.43%	69.20%
10	95971	INJURY-PAIN, KNEE, NOS	0.43%	69.64%
9	37690	EYE DISORDER, UNSPEC	0.39%	70.03%
9	3889	EAR DRAINAGE PAIN,DISCOMFORT	0.39%	70.42%
9	4720	RHINITIS	0.39%	70.81%

Table B-14

Rank Ordered Summary of the Top 50 Ambulatory Diagnoses By Gender for the Garrison Sample for One Year

RANK	FREQUENCY	CODE	DIAGNOSIS DESCRIPTION	FEMALE DIAGNOSIS RANK	MALE DIAGNOSIS RANK
1	230	v65	NO PROBLEM NOTED	1	1
2	138	460	URI ACUTE (COLD)	2	2
3	129	7245	PAIN, BACK, NOS	12	3
4	103	8450	SPRAIN/STRAIN, ANKLE	4	4
5	88	7295	PAIN, EXTREMITY	6	5
6	81	848	SPRAIN STRAIN, SITE NOS	9	6
7	77	462	PHARYNGITIS, ACUTE	11	7
8	66	55890	GASTROENTERITIS	3	10
9	62	7291	MYALGIA	5	11
10	53	311	DEPRESSION NOS	46	8
11	52	70481	PSEUDOFOLLICULITIS BARBAE		9
12	48	7298	PAIN, EXTREMITY (NOT JOINT)	20	12
13	45	84892	SPRAIN/STRAIN, MUSCLES & TENDONS	14	16
14	43	84891	SPRAIN/STRAIN, JOINT (LIGAMENTS)	17	15
15	41	7890	PAIN, ABDOMINAL	7	23
16	40	V700	EXAM, MEDICAL	29	13
17	39	7244	PAIN, BACK, W/RADIATING SYMPTOMS	19	18
18	38	7840	HEADACHE	13	21
19	36	7194	ARTHRALGIA	50	14
20	35	0799	VIRAL SYNDROME NOS	45	17
21	34	8479	SPRAIN/STRAIN, BACK	27	20
22	33	7821	RASH (EXANTHEMS), NOS	35	19
23	31	461	SINUSITIS, ACUTE	15	22
24	27	7870	NAUSEA/VOMITING	16	32
25	24	717	DERANGEMENT, INTERNAL KNEE	34	25
26	24	7231	PAIN, CERVICAL	40	24
27	24	9249	CONTUSION, NOS	28	29
28	23	6926	DERMATITIS, CONTACT, PLANTS, EXCEPT FOOD	26	30
29	22	1104	DERMATOPHYTOSIS (TINEA) PEDIS	38	26
30	22	692	DERMATITIS, CONTACT, NOS	39	27
31	21	v22	PREGNANCY, NORMAL	10	
32	21	v724	POSSIBLE PREGNANCY	8	
33	21	55891	DIARRHEA	31	33
34	21	786	PAIN, CHEST	23	38
35	20	7030	INGROWN TOENAIL	49	31
36	19	919	INJURY, SUPERFICIAL (INCL ABRASION, BLISTER)		28
37	17	463	TONSILLITIS, ACUTE		36
38	17	5990	INFECTION, URINARY TRACT	18	
39	17	87491	LACERATION, SIMPLE (<2 INCH)		34
40	16	72989	MUSCULOSKELETAL PROBLEM, OTHER	21	
41	15	455e	HEMORRHOIDS W/ O COMPLICATIONS		35
42	15	68291	ABSCESS	33	46
43	15	949	BURN, NOS		37
44	15	95971	INJURY PAIN, KNEE, NOS	37	49
45	14	0340	PHARYNGITIS W STREPTOCOCCAL		39
46	14	4660	BRONCHITIS, ACUTE		40
47	14	7862	COUGH	36	
48	13	v719	NO DX OR SIGN GIVEN	47	44
49	13	94401	BURN, THERMAL, 5% BODY SURFACE		41
50	13	99954	INSECT BITE-STING		43

APPENDIX C

Ambulatory Care Data Base

Encounter Forms

PRIMARY CARE PATIENT

PROVIDER

#1 CARE PROVIDER

TIME SPENT

TIME SPENT #2

#2 CARE PROVIDER

- 10 minutes
- 15 minutes
- 20 minutes
- 30 minutes
- 45 minutes
- 1 hour
- 1 hour 30 minutes
- 2 hours
- 2 hours 30 minutes
- 3 hours
- 3 hours 30 minutes
- 4 hours
- 4 hours 30 minutes

PROV #2

Have you seen patient before?

REASON FOR #2 CARE PROVIDER

MARK ONLY ONE

PRIMARY REASON FOR THIS VISIT (MARK ONLY ONE)

DISPOSITION

MARK ONLY ONE

ORDERED OUT OF CLINIC

REFERRALS AND SUPPLEMENTAL DISPOSITION

MARK AS MANY AS APPLICABLE

- Referred to other clinic
- Referred to VA
- Referred to other Fed Fac
- Referred to civilian provider
- Referred to Co. Health Dept
- Other Comm
- Supplemental Care
- Work Limitations
- Other

PATIENT

TODAY'S DATE

DAY | MONTH | YEAR

SPONSOR'S SSN

PATIENT INFORMATION

FMP

BIRTHDATE

DAY | MONTH | YEAR

ADMINISTRATION

UCA DATA

CLINIC CODE

INPATIENT OR REFERRAL CODE

PLACE OF VISIT

MARK ONLY ONE

- Clinic Office
- Ward
- Telephone
- Home
- Other

APPOINTMENT STATUS

MARK ONLY ONE

- Scheduled
- Unscheduled
- Emergency

STATUS OF VISIT

1 Patient seen this clinic last 12 months?

Yes

No

2 Patient being seen for new problem?

Yes

No

080937

INSTRUCTIONS

- DO NOT use ink or ballpoint pen.
- Make each mark heavy and black.
- Fill ovals completely.
- Erase cleanly any mark you wish to change
- Make no stray marks

ONLY ACCEPTABLE MARK

DO NOT MARK IN THIS AREA

VISIT AND

OTHER TRAUMAS

SKIN & SUBCUTANEOUS

GENERAL SIGNS & SYMPTOMS

P&M

JOB RELATED ILL/INJ (NOT LOD DET)

UNLISTED DX
(if not listed in columns above)

EVALUATION/SERVICES/PROCEDURES (MARK AS MANY AS APPLICABLE)

EXAMS

IMMUNIZATIONS

MAKE NO MARKS IN THIS AREA

MAKE NO MARKS IN THIS AREA

080937

AMBULATORY CARE DATA BASE

COMPLETE LIST OF OUTPATIENT ENCOUNTER FORMS

ALLERGY/IMMUNIZATION PATIENT
ALLERGY/IMMUNIZATION SHORT FORM
AUDIOLOGY/SPEECH PATIENT
CARDIOLOGY PATIENT
CARDIOTHORACIC PATIENT
DERMATOLOGY PATIENT
ENDOCRINE/NEPHROLOGY PATIENT
E.N.T. PATIENT
GASTROENTEROLOGY PATIENT
GENERAL MEDICINE PATIENT
GENERAL SURGERY PATIENT
INFECTIOUS DISEASE PATIENT
NEUROLOGY PATIENT
NUTRITION CARE PATIENT
OB/GYN PATIENT
OCCUPATIONAL HEALTH PATIENT
OCCUPATIONAL THERAPY PATIENT
ONCOLOGY/HEMATOLOGY PATIENT
OPHTHALMOLOGY PATIENT
OPTOMETRY PATIENT
ORTHO APPLIANCE
ORTHOPEDICS PATIENT
PODIATRY PATIENT
PAIN/PHYSICAL MEDICINE PATIENT
PEDIATRIC PATIENT
PHYSICAL THERAPY PATIENT
PLASTIC SURGERY PATIENT
PREVENTIVE MEDICINE/CHN PATIENT
PRIMARY CARE PATIENT
PSYCHIATRY PATIENT
PSYCHOLOGY PATIENT
PULMONARY PATIENT
RADIOTHERAPY PATIENT
RHEUMATOLOGY PATIENT
SOCIAL WORK CLIENT
UROLOGY PATIENT
SHORT FORM
REPEAT PROCEDURE FORM
PATIENT REGISTRATION FORM
PROVIDER REGISTRATION FORM

AMBULATORY CARE DATA BASE

PROCEDURES APPEARING ON ACDB "SHORT FORM"

BLOOD PRESSURE CHECK
CONSULTATION W/SECOND PROVIDER
(PATIENT NOT SEEN)
EFMP CODING
EKG W/O INTERPRETATION
IMMUNIZATION ONLY
INPROCESSING MED SCREEN
POR SCREEN
PRESCRIPTION REFILL W/O EXAM
PRP SCREEN
SECURITY CLEARANCE SCREEN
SHOT RECORD REVIEW
TB SKIN TEST ADMINISTERED
TB SKIN TEST READ
TELEPHONE CONSULT DOCUMENTED

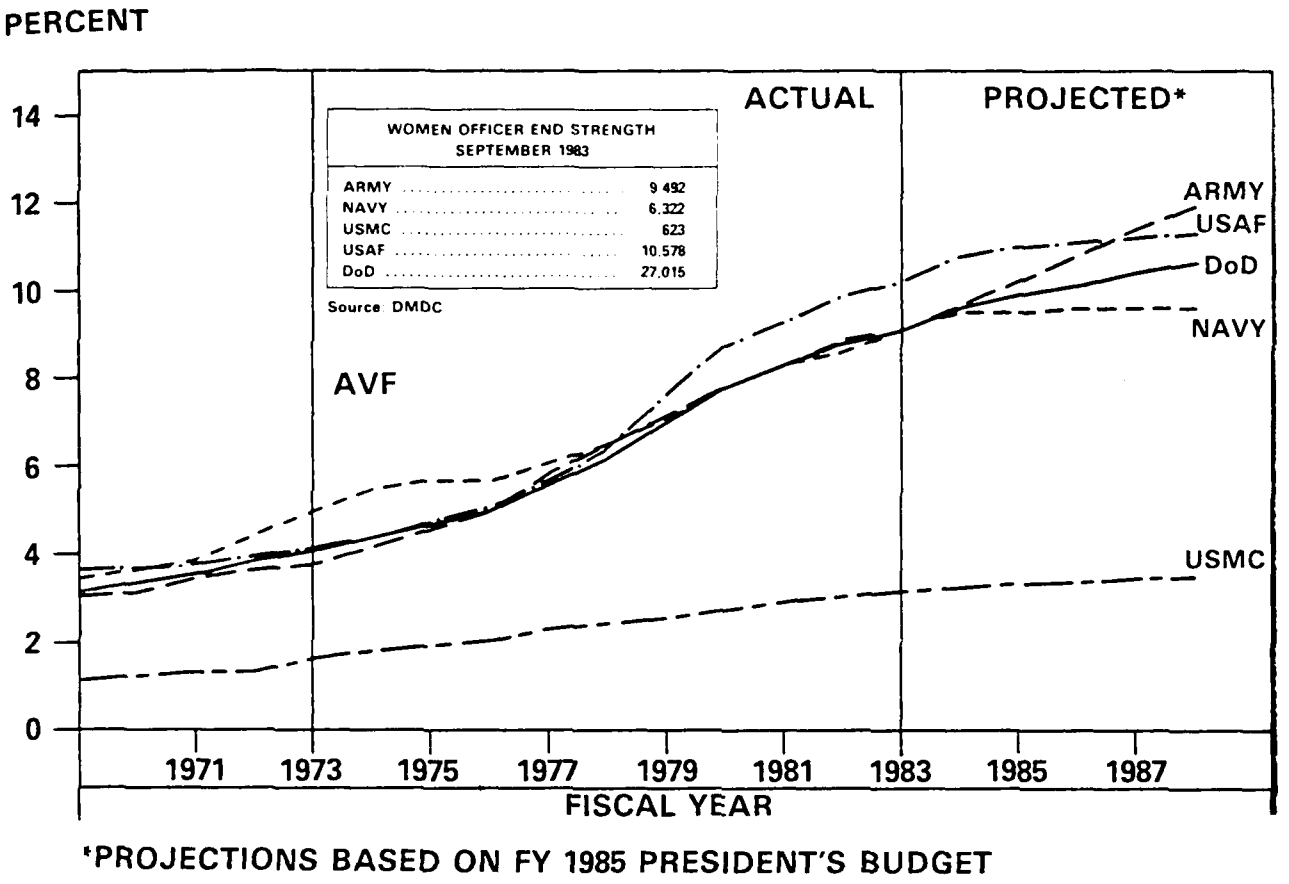
NOTE:

EFMP: Exceptional Family Member Program
POR: Processing for Overseas Replacement
PRP: Personnel Reliability Program

APPENDIX D

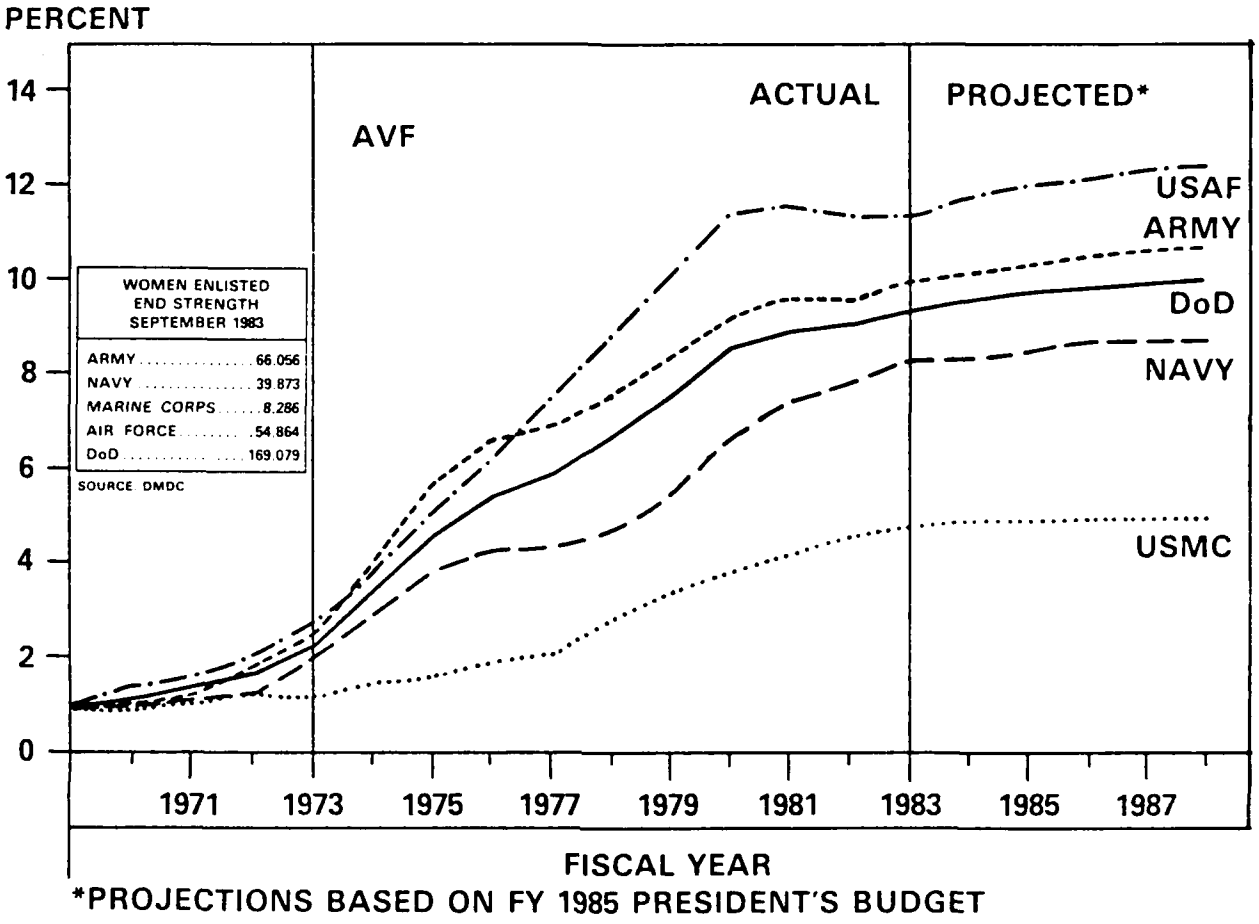
Figures

Figure D-1. Women as a Percentage of Active Duty: Officer End Strengths.



Note: From Military Women in the Department of Defense, Vol II, (p.3). Department of Defense, April, 1984, Washington, D.C.: U.S. Government Printing Office.

Figure D-2. Women as Percentage of Active Duty: Enlisted End Strengths.



Note: From Military Women in the Department of Defense, Vol II. (p. 39). Department of Defense, April, 1984, Washington, D.C.: U.S. Government Printing Office.

END

DATE

FILMED

MARCH

1988

DTIC